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PRIMARY HEALTH CARE MANAGEMENT IN NIGERIA

Doctor of Philosophy

University of Aston in Birmingham

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THESIS SUMMARY

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This research project sets out to assess if the PHC system in rural Nigeria is effective or ineffective by testing the research hypothesis:

'PHC can be effective if and only if the Health Care Delivery System matches the attitudes and expectations of the Community'

The field surveys to accomplish this task were carried out in IBO, YORUBA and HAUSA rural communities.

A variety of techniques have been used as Research Methodology and these include questionnaires, interviews and personal observations of events in the rural community.

The Thesis embraces three main parts. Part I traces the socio-cultural aspects of PHC in rural Nigeria, describes PHC management activities in Nigeria and the practical problems inherent in the system. Part II describes various theoretical and practical research techniques used for the study and concentrates on the field work programme, data analysis and the research hypothesis-testing. Part III focuses on general strategies to improve PHC system in Nigeria to make it more effective. The research contributions to knowledge and the summary of main conclusions of the study are highlighted in this part also.

Based on testing and exploring the research hypothesis as stated above, some conclusions have been arrived at, which suggested that PHC in rural Nigeria is ineffective as revealed in people's low opinions of the system and dissatisfaction with PHC services. Many people had expressed the view that they could not obtain health care services in time, at a cost they could afford and in a manner acceptable to them. Following the conclusions, some alternative ways to implement PHC programmes in rural Nigeria have been put forward to improve and make the Nigerian PHC system more effective.

HEALTH CARE:

NIGERIA : PRIMARY HEALTH CARE :
HEALTH CARE MANAGEMENT SYSTEM

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I am most grateful to my colleagues and many seminar participants for their reactions and criticisms of my seminars and pre-event trials, which helped materially to make research methodological tools more instructive.

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INTRODUCTION

At this micro-level Research study in Nigerian rural communities, there are several features which tend to show that the Nigerian PHC systems in three major Nigerian provinces - Ibo, Yoruba and Hausa rural communities are ineffective. These include wide variations in accessibility, availability, utilisation and output of basic health care services to the Nigerian rural populations.

At this grass-root level, the village people themselves have not shown interest in PHC development programmes. To them, the Nigerian PHC systems have not focused attention on mobilisation of community support/involvement in PHC programmes; improvement in environmental sanitation; nutrition and health education; maternal and child health etc. The Health Centres and dispensaries provide little or no preventive service but tend to concentrate their effort on curative measures. The shortage of doctors and other medical staff in the basic health units and communities create low service productivity situation and inefficiency. The morale of health workers in general is low due to lack of motivation and incentives, insufficient/or lack of training opportunities and promotion; diverted supervisory responsibilities and lack of co-ordination among health staff. These tend to demoralise and frustrate health workers and make them not to comply with local health needs and requirements.

The village people expect that the health care delivery personnel in their respective localities should be able to provide them with decent basic health services at a reasonable cost, treat them like responsible people when they attend clinics, health centres and dispensaries; and above all

reduce their waiting-time for medical consultation and treatment etc. But these expectations of the people are rarely met or matched with the type of medical treatment, medical treatment procedures, medical services etc which the medical staff in these rural communities provide for the village people. However, the cultural attitudes of these people themselves tend to hinder both PHC development and effective health services in their respective communities. The people's customs and tradition, superstitious beliefs and practices relating to treatment of certain diseases (measles, cholera, leprosy, Malnutrition etc); family planning system (family size, pregnancy advice etc); religious practices (Moslem, Christians - Catholicism, Protestants etc); the view of their own health needs; their cultural variations and social and ethnic divisions all tend to constitute barriers to effective PHC services.

These attitudes of the people, their customs and tradition and their beliefs in turn frustrate and restrain the health care delivery professionals in their wish to provide them with basic health care services.

The research study, therefore considers two main camps - the people's attitudes, their expectations and their health needs on one hand; and the health care delivery systems and the medical professionals/practitioners' role in providing the needed essential services to the people on the other, to see if the latter matches the former.

This exercise involves the testing of the hypothesis:

"Primary Health Care can be effective if and only if health care delivery system matches the attitudes and expectations of the community".

Based on testing and exploring the hypothesis, strategies for improving the PHC systems in rural Nigeria were designed and recommendations on how to implement these strategies to improve PHC services are stated, placing heavy emphasis on effective primary health care systems for these rural communities based on: Basic health care provision at the periphery and primary level; A thorough system of preventive care; A very high level of popular participation and involvement of the community in health; and a new push to democratise the health service and make it more humane and more responsive to the community's health needs.

Therefore the research study serves to hypothesize that Nigerian strategy for developing a highly decentralised and effective Primary Health Care delivery system can only be accomplished if the health care delivery system matches the attitudes and expectations of the local community. This undoubtedly means that for primary health care to be successful and effective in Nigeria, there has to be a concrete policy and national will, an existing mutual-self help concept, training and decision-making involvement of communities and their willingness to accept change if these would lead to improvement of life, decision-making through discussion, adequate professional guidance and supervision and the involvement of the traditional health personnel. Some important conclusions were arrived following the completion of the research investigation in the three rural communities of study. These conclusions stipulate that the Nigerian PHC systems in these rural areas are ineffective, as revealed in people's low

opinions of the system. The village people were also dissatisfied with the PHC services, for example, many people had expressed the view that they could not obtain health care services in time, at a cost they could afford and in a manner acceptable to them. Following these conclusions, some alternative ways to implement PHC programmes in the rural Nigeria to improve and make PHC systems in these localities more effective have been recommended to different interest groups and local health authorities in Nigeria.

The structure and organisation of the Thesis:

There are three main parts that make up the structure of the thesis. Each part bears a main heading and is organised to contain some chapter(s), which are subsequently sub-divided where appropriate.

On the whole there are 8 chapters with different sub-headings. A comprehensive summary of the structure and organisation of the thesis is shown below:

Chapter 1 traces the socio-cultural aspects of PHC systems in Nigeria and describes the cultural variations in Nigeria by looking into the Hausa, Ibo and Yoruba profiles in relation to health issues and their respective attitudes to PHC services in their respective localities. This chapter also describes different management activities in Nigerian PHC systems and the practical problems inherent in them.

Chapter 2 concentrates on research methodology and the application of the most appropriate research methods to the Nigerian field-surveys. The

research methodological tools used to collect data during these field surveys include a variety of techniques - interviews, questionnaires, personal observation etc.

Chapter 3 looks at the fieldwork programme and fieldwork activities and the difficulties which the research investigator experienced during the periods of survey.

Chapter 4 shows how the data collected during the field surveys are analysed. The data analysis is split up into two different sub-sections - the analysis of data obtained from interviews and personal observation; and the analysis of data obtained through the completion of health attitudes survey. The latter section was completed with the aid of the SPSS package - a package which involves the application of CONDESCRIPTIVE statistical analysis with the HARRIS 500/800 systems.

Chapter 5 here the research hypothesis was tested and the findings and conclusions of the tests were summarised. The recommendations on ways to improve PHC effectiveness in rural Nigeria have been shown.

Chapter 6 focuses on general strategies to improve PHC system in Nigerian rural communities and make it more effective.

Chapter 7 the research contributions to knowledge are detailed here and these include research contributions to the village people and the rural community; and research contributions to scientific knowledge.

Chapter 8 the final chapter which contains the summary of the main conclusions of the research study.

PART I

CHAPTER ONE

PHC IN CONTEXT

A. THE SOCIO-CULTURAL ASPECTS OF PRIMARY HEALTH CARE IN NIGERIA

1.1 THE NIGERIAN PROFILE

There are well over 200 separate languages and ethnic groups in Nigeria, its land varies from dense tropical rain forest to arid desert savannah; some of its people are extremely wealthy, and many live at the barest level of subsistence. But the modern economic and political realities which British rule initiated have turned the survival of Nigeria as a single nation into an imperative.

The British Colonialists, who could recognise a workable political system when they saw one, left the running of northern Nigeria very much in the hands of Islamic autocracy, and, when Nigeria became independent, it was the Sarduana - the SULTAN OF SOKOTO and his EMIRS who had ultimate control of the Federal Government of Nigeria, because of the vast size of the Muslim North compared with the two southern regions - East (the Ibos) and West (the Yorubas).

The Constitution of Nigeria at independence divided the country into three regions, each dominated by a racial group. The South-West was almost entirely Yoruba, the South-East the Ibo; these two tribes were dominated

by the larger Hausa Muslim of the North. Both the Ibos and the Yorubas tended to regard the northerners (the Muslims) as feudal and backward, but they themselves are deeply divided culturally and politically.

For over a thousand years, the Yorubas have occupied a vast area to the west of the Niger River, and developed there a hierarchical society which is inextricably interwoven with their well codified religion. It is a religion which has a pantheon of gods; spiritual beings and ancestors, under a Supreme creator called "Oduduwa" or "Olodumare" ; and from this model flowed all temporal authority, with Oni of Ife at the head, and the "Obas" of the various Yoruba city-heads ranked in order of seniority under him.

In the fertile farming areas on the east-bank of the Niger River, altogether different and more polyglot societies developed - THE IBOS.

Among the Ibos, Achebe (1962) stressed that proverb is the palm-oil with which words are eaten. The Ibos are the more dominant racial group of Nigeria and the Ibo society was almost the reverse of hierarchical form of authority, with each Ibo village or town ruled by a Council of elders. However, every individual male enjoyed the right to debate or even reverse the council's policies at a village assembly by a popular consent - a traditional form of democracy which distinguishes the Ibos from the rest of Nigerian tribes. It was a traditional government by unanimity, and the emphasis on the supremacy of the individual made the Ibos, unusually for Africans, remarkably success-oriented.

Long before the Europeans, especially the British, started trading with Nigeria, the Ibos had built up a formidable long-distance trading economy of their own (like the Jews). So when Nigeria entered the modern industrial world, it was the Ibos who most easily adapted to it.

Nigeria's cultural diversity, therefore, is far greater than, say the whole of Europe put together, and it is not surprising that every aspect of Nigerian life is coloured and split up on racial rather than on theoretical lines. It is under this type of cultural environment and variations that Primary Health Care (PHC) is being initiated, developed and managed to serve the entire Nigerian populations especially the rural populations and to receive a comprehensive health coverage of 95 to 100 per cent by the year 2000. Much the same, Nigerian racial and cultural divisions are deeply rooted into Nigerian politics, hence the creation of the 12 then 19 states which was a deliberate political effort by the military regime (1966-79), to break up the old Ibo, Yoruba and Hausa dominated power bases and to give the minority groups a voice in government.

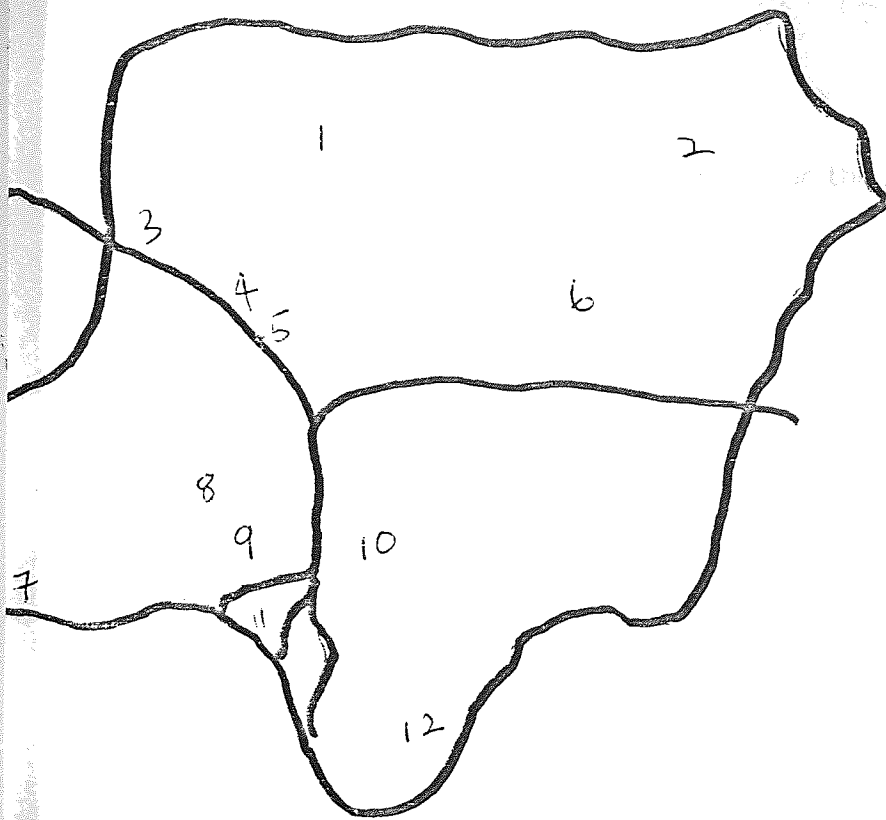
Traditional medicine is widely recognised in Nigeria and Nigerian traditional healers, especially those from Hausa land, tend to migrate within and outside Nigeria to market their vegetable, animal and mineral substances along overland pilgrimage route to Mecca in Chad (Works, 1976); Sudan (Trimingham 1965); Southern Cameroon (L.Ndaka); Ghana (Twumasi, 1975); Mali (Imperato 1977); Gambia (K CCham); Lower Zaire (Janzen 1978).

The Ibos, Yorubas and Hausas have different medical concepts and different approaches to traditional practice. Medical treatment and causes of ill-health are mostly associated with witchcraft; superstition and intercession with spirits in connection with 'Sapona' the Yoruba god believed to cause small-pox; the Igwekala the god of thunder which the Ibos believe can claim life slowly but surely or many other local deities. The

Hausas hold ill-health to be caused by three major ailments - Allah the Islamic god; personal attack especially physical attack and violence and impersonal hazards especially those coming from environmental and behavioural risks.

The choice for any particular health care in Nigeria, particularly in the rural areas, between traditional care or modern health care for different categories of sickness and for specific illnesses may depend upon several factors as shown in the studies by Maclean (1966); Schwartz (1969); Colson (1971); Nchinda (1977). These studies suggested that the choice between the western type and traditional therapy is based on several but different criteria such as perceived aetiology as described by Press (1969) and Colson (1971); perceived seriousness of the illness as described by Gould (1957) and Agualimpia (1971); the success or failure of successive attempts to effect a cure as described by Schwartz (1969).

Peil (1977) in describing the major tribal Groups of Nigeria identifies twelve tribal groups, but she prefers to refer to them as ethnic groups, as she tries to avoid what she considers to be 'the perjorative implications and the primitive undertone' of the word tribe. These twelve tribal groups are further sub-divided into about two hundred sub-groups as contained in the study by Nagziger (1977). The locations of the twelve tribal groups can be shown as follows:



1. Hausa
2. Kanuri
3. Serkwa
4. Gwari
5. Nupe
6. Tiv
7. Yoruba
8. Weppa Wano
9. Yako
10. Ibo
11. Ijaw
12. Efik

There are some cultural differences which exist among the three major tribes mentioned earlier: the Ibo, in the South-East; the Yoruba in the South-West; and the Hausa in the North. These main tribal groups bear a dominating influence on the minority tribal groups, for example, in terms of language the Hausa language dominates other smaller tribes in the north which makes it possible for the majority of the northern populations to communicate in Hausa language in the public gathering places such as market places, places of worship etc. In the entire Yoruba land, or Ibo land, the dominating spoken languages are Yoruba and Igbo while other spoken languages are in the minority within the same Yoruba or Ibo tribes.

Beals et al's model of major components of cultural systems (1977) can be used to illustrate the point that Nigerian major tribal groups (Ibo, Yoruba and Hausa) possess all the necessary features that tend to make them to be regarded as separate cultural groups. The Ibo, Yoruba or Hausa tribal groups consist of separate and different people who exhibit behavioural characteristics peculiar to their respective tribes. While the Hausa and the

Yoruba tend to bear distinct tribal marks on their cheeks, faces etc the Ibo do not have any tribal marks. The appearance in physical terms also tend to differ in that the northerners being closer to arid desert and hotter regions have darker skin colour unlike the southerners with more brown skin colour. Furthermore, it has long been established that these three main tribal groups also emerged from different historical and cultural traditions. Many studies (Ademunwagan 1976, Odebiyi 1977) have also shown that there are wider cultural and tribal differences between the Ibos and the Hausas than between the Yorubas and the Hausas. These basic cultural differences tend to explain the reasons why the Ibo, the Yoruba or the Hausa sometimes see things differently. As a result of these tribal differences amongst them, the illness behaviour of the Ibos, the Yorubas or the Hausas is totally dependent upon the cultural and ethnical qualities each group possess which are passed from one generation to another. Further cultural differences of the Ibos, Hausas and the Yorubas can be established in their cultural profiles.

1.1.1 The Hausa Profile

The Hausa people are culturally and historically believed to have emigrated from Western Sudan of North Africa to northern Nigeria where they settled for generations. The geographical location of the area occupied by the Hausa people is estimated to be about 108,881 square miles, and located between latitudes 10° and $13\frac{1}{2}^{\circ}$ north and between longitudes 4° and 10° East. The local dialect of Hausa people is known as Hausa from which the people themselves were described or called the Hausa. The classification of Hausa language by Greenberg (1963) as a member of the Chadic group of the Afro-asiatic family of languages suggests that the language closely

related genetically to Arabic, Hebrew, Berber and other members of the Afro-asiatic family than to many sub-Sahara African languages. But in a closer examination of Greenberg's classification, Kraft and Kirk-Greene (1980) suggested that Hausa is not a typical tropical African language. The Hausa people are clearly described to have originated from 'Hausa Bakwgi' or the seven historical states of Kano, Katsina, Daura, Zazzau, (Zaria); Biram, Gcibir and Rano, which are all located within the modern Sokoto, Kano and Kaduna States of Nigerian federation.

In terms of demography, the growth of Hausa population in the 19th and 20th centuries had been quite staggering as the current population-statistics in Nigeria put it to 24.8 million with little or no chance for a family planning system to be introduced or accepted due to Moslem beliefs relating to pregnancy and childbirth.

The geographical location of Hausa states reveals that their vegetation is mainly Savanna with such climatic features and characteristics found in other world Savannah regions and climates, with the rainfall averaging between 40 and 45 inches per year; while the temperature varies from 11.5°F in the wet season to 100°F+ in the hot dry season. There are other intermittent weather conditions mainly in the form of harmattan - a dry and dusty windy weather with some extreme and freezing cold temperatures.

The Hausa staple foods are locally grown with some traditional subsistence farming methods. While some domestic animals are reared for food and profit. The Hausa people grow guinea corn, millet, maize and keep poultry farm while a good many of them are cattle wanderers who move their

animals to different locations for grazing. They also have other supplementary professions as described by Smith (1965), who listed the following Hausa occupations and crafts:

The Hausas classify their men as hunters, fishers, builders, thatchers, butchers, tanners, leatherworkers, saddlers, weavers, dyers, woodworkers, blacksmiths, brass and silversmiths, calabash workers, pot makers, drummers, musicians, praise singers, barber surgeons, tailors, embroiders, washermen, porters, commission-agents, traders, makers of sweetmeats, mat and basket makers, tobacco grinders, herbal medicine specialists, clerics, rulers, officials and their agents.

The rapid modernisation programmes in Hausa land have affected some of these occupations as most of them are in decline. Moreover, with the massive urbanisation schemes in the north, many villagers who grow crops and rear cattle have been migrating to towns and cities to look for more gainful employment and better paid jobs.

The matrimonial practices of the married Hausa women forbids them to come out of their homes by the daytime. This is to prevent any man from seeing them except their husbands. Their movement at night-time is also restricted but if it becomes inevitable for them to go somewhere at night, they must cover their heads and their faces while being escorted by another member of their family, normally a teenage boy.

In almost every home of a married Hausa women, the popular sign on the door cautions and warns people 'not to enter' or 'Ba shiga' which is a popular Hausa warning on the door of married couples. Too much restrictions are

imposed upon married Hausa women and one of the consequences of this is the total absence of Hausa women in paid jobs and employment. Rather, these women are expected to be good, loyal and able to bring up children, prepare meals for their families in their homes and do some local weaving, basket making and clay-pot moulding. However, the number of Hausa women in full-time paid jobs are also increasing but they tend to be the single or unmarried women who are sometimes self-employed or according to Smith (1959) engage themselves as praise singers or prostitutes.

The Emirs or Sultans are the Hausa Kings who rule them as dynasties. These kings are not politically appointed but the thrones are inherited - heritage in which the child/son of the Emir becomes the natural successor or heir to the throne. The Emirs are very much respected by the Hausa people and these natural rulers have their own palaces, eunuchs, slaves who work for them at home, as well as on the farms, granary, the royal insignia and drums. The Emirs have their own security officers comprising of warders, policemen and executioners.

This type of rule by the Emirs is not yet destroyed by modern life of the Hausa people as many Hausa societies today still have Emirs and Sultans, including the Emir of Kano and the Sultan of Sokoto, who are also federally recognised in Nigeria to be traditional leaders with specific traditional functions which do not conflict or interfere with Federal or State Government official administrations or programmes. These Hausa kings have the right to appoint other Hausa chiefs to look after Hausa communities and villages and also to appoint those people who directly assist them in their system of Islamic rule: these include priests, judges, Islamic legal assessors, official scribes and the Sarkin Mallamai - chief

mallam who stay with the Emir to offer him official advice in government, non-government and religious matters as they arise.

The Hausa Moslems have Islam-related culture as described by Smith (1965): "For Hausa, Islam is a way of life as well as a set of beliefs in Allah and his prophet. The five daily prayers, attendance at Mosque on Fridays, the three main annual festivals, the yearly grain tithe, the annual fast of Ramadan, and the recurrent fact of pilgrimage together represent local Islam most forcefully. In addition, the Courts administer Muslim law modified by Hausa custom and the traditional schools teach Muslim texts. Much of Hausa folklore is Islamic, together with urban house types, dress, script and other cultural forms; and the standard Islamic injunctions and taboos are regularly observed in the country towns as well as in the cities. Almost every local Hausa community has two official priests to preside over Friday mosque and the two yearly sallah festival. Hausa people also tend to have different attitudes to life in the way that has been described by Smith (ibid): traditional attitudes which "stress patient fortitude in the face of adversity, self-control, thrift, pride in workmanship, and enjoyment of social relations. The commoners are habituated to obedience and tolerance, their rulers to political control. Kunya (shame) is a major sanction compelling individual conformity to custom."

Illness perception and illness behaviour of Hausa

The Hausa people believe that the decision to seek or not to seek medical treatment and the choice of treatment strategy for any particular illness episode should only be embarked upon with the approval of the elderly members of the family or the adult patient. The way the Hausas see illness

and its treatment measures may not exactly correspond to those of westerners and their health practitioners, but this does not place Hausa belief system about illness and its management in an inferior position. Study by Horton (1967) claims that the validity of any belief system is dependent on its ability to provide satisfying, or, internally consistent and rational explanations for sickness and other significant events.

The Hausa people have cultural beliefs that are Islam-oriented and Hausa belief system is always successful for the Hausa people when offering diverse explanations as to the nature, causes and treatment of a number of the common illnesses which they experience. The measures which they adopt when treating illness are also culture-specific: explained within the same context of the wish of Allah (the Islamic god). Allah is claimed to provide a universally applicable explanation for the general burden of illness or the unexpected failure of successive therapies to bring about a cure.

The definition of 'Health' by the Hausa is different from that offered by the World Health Organisation (1946) which defines health as a state of complete physical, mental, social and economic well-being and not merely an absence of disease or infirmity. But the Hausa definition or description of health though different from (WHOs) has some similarities with it also. The Hausa believes that health is far more than the absence of disease, rather, it is a general state of physical and social well-being which incorporates such characteristics as good relations with family and social contacts, a settled religious and moral state, freedom from danger and fear, success at work and in personal affairs, and the absence of sickness.

Although every Hausa individual prays for good health and prosperity, the health conditions of the Hausa people tend to show that there is no basis for comparing the typical Hausa disease patterns and the subsequent deaths arising from them with the low statistical figures of mortality and morbidity rates recorded in several developed countries. The picture in Hausa land and indeed the whole of Nigeria tends to show that infant mortality rate is still high, while the common health conditions which are still killers in Hausa communities include malnutrition (Kwashiorkor), complications of childbirth, blindness, malaria, leprosy etc.

Every Hausa individual strongly believes that 'health is wealth' which means 'Lafiyar jiki arziki ne' in Hausa language. Health-seeking behaviour is also expressed through several Hausa local idioms and proverbs. There are religious obligations for the Moslems to observe certain Islamic principles and guidelines in order to stay healthy or prevent any impending health hazards. The failure to observe health behavioural codes according to Moslem laws may lead to Hausa individual losing respect or popularity in his local community. It may also mean disobedience which could bring personal health crisis to an individual or the community as a whole. Islamic gods may decide to punish Moslems who do not obey religious laws of Islam or conform to its norms, and this punishment may not only be restricted to imposing ill health. Allah may decide to impose punishments in the form of severe drought, poor harvest, famine, serious epidemics, riots and civil unrest, family instability or chronic diseases such as leprosy attacks. There are some diseases which Moslems are too ashamed of and which must remain un-Islamic to contract, for example, the venereal diseases and other sexually transmitted diseases through prostitution: the kind of diseases believed to pollute and endanger community life.

There are some of the Hausa greetings which are used to ask about one's health, for example, 'Lafiya?' which literally asks "How is your health?" or 'Gida Lafiya' which responds 'The family is very well and healthy' or 'Ka Kwai Lafiya' which asks 'Did you sleep well?'.
The common practice amongst the Hausa villagers is, while recognising the importance of them to have good health, they seldom admit at first that they are unwell even though they may be very ill. Those who seek medical treatment (whether modern or traditional) always attempt to express that they are very well or getting better to the same question of 'Lafiya?' - 'How is your health?' This formality having been expressed in a friendly gesture or greeting, the Hausa patient then turns round to explain his or her real state or health condition but in a more polite fashion to assist the diagnosis and treatment experts.

As every Hausa individual tries to maintain his health, he must also try to observe certain rituals of Islamic religion. Naming ceremony of infants, for example, is accompanied by rituals and performance of locally administered surgical routines of uvulectomy. The post-partum care of the newly delivered mother and her infant is vitally important and highly recommended. As a necessary step, the mother is asked to stay inside on a heated bed, placed on special diets rich in potash (kawa) and commence a regular scalding with hot baths for up to 35 days or more. A strict observance of rituals also mean obedience to Allah and adherence to Hausa customs and beliefs - all these being a surer way for safeguarding one's own health as well as his family's. But in other health matters or conditions it is customary for Hausa patients to buy herbal and protective

medicines which include 'Laya', the leather pouch charms; 'Rubutu', the Koranic ink medicine; or 'Wanki' the purgatives.

The most common sickness-terms which the Hausa people use more frequently include 'Cuta' meaning disease or 'Ciwo' meaning pain. These terms may be used to express some specific symptoms of illness also, for example, 'Giwa Baya' is used to express backache pains; 'Ciwan Kai' to express headache pains; 'Cutar Barci' to express sleeping sickness etc; 'Ina jin Gwo' means 'I am not feeling well'. Yet some Hausa illness terms can be used in combination to express the same health condition, for example 'Bana jin dadin jiki or jikina ya luface' all expressing or saying 'my body does not feel good or my body is bad enough'.

In Hausa land, sickness is generally proclaimed the active force that victimises the patient. The sick Hausa must therefore receive abundant sympathy from relatives and friends, unless the sickness is self inflicted from say actual suicide or suicidal tendencies or where one has deliberately taken his own life or other similar circumstances. There are considerable emotional ties of the families and other well wishers who pray consistently for total recovery of their sick person but this kind of emotional ties tend to create tension within an extended Hausa family as family income may be reduced or stopped while attention is being paid to the patient. Many other opportunity costs may also be foregone. Patients may use other phrases to describe both the symptoms and the painful nature of an illness, for example, 'Shiga' means enter; 'Buga' means beat; 'Kama' means coughing. It is believed that some illness may remain dormant in the body only for a short period of time before surfacing to be more virulent. The common illnesses in this group are the malaria, measles, fever etc which stay in

latent form for a while before their sudden attacks when the Hausas say 'Giwo ya tashi' meaning 'The illness has risen up'. Many traditional medicines are claimed to be very suitable in dealing with or controlling many of the hot and cold illnesses and true signs of real cure must show some physical evidence that the illness has been stopped, prevented or totally cured through effective traditional therapy. In such conditions, the physical evidence may be shown in the form of abundant urine, vomiting, skin rashes, profound sweating, excessive sneezing etc.

'Kwantacce' is an ill-health usually suffered by Hausa women in which a normal progression of pregnancy is believed to have been stopped or halted by some evil spirits. Some of these Hausa women sometimes use 'Kwantacce' also as an excuse to evade some of their social responsibilities or obligations in Hausa communities or to justify their ritual inclination and tendencies to worship 'Bori' the spirit possession ceremonies, in contrast to barrenness-associated ceremonies in which 'purdah' is sedatively used in greater quantities. Infertility in women is not only a social and health problem to Hausa society, but also acknowledged as bad or serious omen which is spirit-caused. In several cases which are associated with infertility, the very experienced Hausa traditional Birth Attendants know how to arrest them so that a woman can become pregnant in the normal or natural way. Such professional and experienced traditional Birth Attendants tend to have some extraordinary powers or supernatural vision or gift of second sight from which they draw their inspiration and ability to effect cure of any unusual or spirit caused infertility. Under Islamic guidance, these experienced Traditional Birth Attendants also have different human qualities such as being born with caul, having and being capable of interpreting dreams, suffering some minor illnesses which

reduce their mental ability to think and behave rationally instead of abnormally, encountering special objects or oddly shaped stones, a knife, scissors, a shell, a carving or a statue. All these qualities are gifted to them to strengthen their spiritual powers that may from the onset in their childhood be shown in the form of Islamic signs, which in turn, can be interpreted by the Islamic diviners who explain the traditional birth attendant's role as related to or associated with humanitarian services. If a traditional birth attendant is chosen under Islamic law to do a humanitarian service, it is almost compulsory since any disobedience may give one some serious punishment from the Allah in one way or the other.

The majority of Hausa people do not like much publicity about their ill health or health problems. Privacy and secrecy are key to avoiding widespread knowledge that a Hausa individual is, for example, suffering from leprosy disease. This is not much helping to achieve prevention or to control the disease but a personal decision deliberately taken by some of the Hausa Lepra to avoid the stigma that is always attached to leprosy sufferers. Furthermore, the Hausa do not cherish 'Kunya', that is shamefulness that goes with leprosy victims. But equally, superstition and cultural beliefs about leprosy and venereal diseases tend to heighten the fears of many Hausas who believe that if one even mentions the name of the disease directly instead of the disguised locally-invented names, the person will automatically become a victim himself. Venereal disease, for example, should be called instead, the disease of the lower abdomen or bottom sickness. In a situation where illness is recognised traditionally to be caused by spirits, special care and professionalism is called for for the fear of antagonising spirits and consequently aggravating the health problem further.

The external classification of illnesses is different from the international classification of illnesses for the Hausas who have 'jiki' the outerbody or 'Ciki' the inner body illness classifications. 'Ciki' is further sub-divided into inner sub-system which contains the digestive organs. 'Jiki' the outerbody, envelops the lungs and the heart. Other illnesses such as epilepsy, lunacy, intercessional ailments are held rigidly to be caused by evil spirits. The more common illnesses of 'Atuni', the dysentery; 'Giwan mara', the constipation; 'Kullewar ciki', vomiting; 'Zawayi', the diarrhoea are few examples of diseases of digestive system. Similarly the illnesses of the outerbody include 'Sanyi jiki', the joint pains; 'Kuraje', the skin rash; 'Zazzabi', fever; 'Giwan jiki', the general lethargy.

In Hausa people's experience, extreme cold weather or extreme hot weather may cause some ill-health. 'Sanyi' the cold weather may cause fevers (zazzabi), malaria (jante), infant convulsion complicated with malaria (raba). Dampness, rising damp are associated with rainy season when dew, cold weather (dashi) etc must be avoided so that people do not catch cold, or infant diseases (Giwan goyo) such as fever, boils (mono), whooping cough (tari mai harawa); childrens illnesses (Giwan yara) of which measles (gurda) is a real life-threatening illness to a greater number of Hausa babies and children. In the adults, gonorrhoea (Gwan Sanyi), jaundice, anaemia (shawara) are associated with old age. Senility or progressive mental weakness due to old age makes old people to behave in a childlike manner.

Complications of pregnancy and childbirth (Giwan mata) and some other women's illnesses are not treatable in hospitals because they may have been caused by evil spirits (Giwan Iska) or witchcraft (maita).

Illness, origins: The majority of Hausa illnesses in the widest sense originate from three main sources:

1. Allah the Islam god
2. Impersonal hazards: environmental, anti-social behaviour
3. Personal attack by:
 - (i) Spirits 'Iskoki'
 - (ii) Witchcraft 'Maita'
 - (iii) Interpersonal conflict

To say that illness is attributable to Allah's wrath is merely to acknowledge his omnipotence, but in the case of impersonal hazards, the origin may come from something that is accidental which can happen to anybody. On the other hand, personal attack causes anxiety because some specific individuals are victimised by malevolent other individuals or natural forces in which a lingering death or chronic illness are the penalties which the patients or the victims pay.

1. THE ALLAH:

The majority of Hausa people believe that all good or bad things are given to people by Allah. It therefore follows that Allah is also capable of punishing certain people with dreadful illness or imposing on them some misfortune. Correspondingly, Allah is very competent of stopping any misfortunes and can quickly cure illness and alleviate people's sufferings. The frequent references to Allah's potentials and powers may be interpreted by a non-Hausa as an evidence of a fatalistic outlook. However, it is an active fatalism which recognises the need for self

body dehydration through profound initiative, patience and acceptance in health matter. According to one Hausa proverb 'Allah says get up so that I can help you' - "Allah ya ce tashe in taimake ka". This is also how the Hausa people express man's relationship with Allah, but the Christians may say God helps those who help themselves. Allah is also a helping hand of providence.

2. IMPERSONAL HAZARDS: Domestic or Occupational.

Impersonal hazards, as the Hausa people see them, are wide ranging. Improper feeding habits may be fatal e.g. choking of oneself to death while a meal is in progress. Some domestic impersonal hazards may be associated with some Hausa popular domestic activities such as grinding of millet, corn, tobacco, and other cereals or in connection with such daily activities like fetching of both drinking water and firewood. Excessive smoke in the kitchen may constitute some health hazards which may eventually lead to some form of eye-problems or defects.

There are also other environmental hazards such as those coming from living creatures and some specific and dangerous environmental problems. Behavioural aetiology includes the over-consumption of certain foods or taboos, personal violation of some social norms, contagious disease.

The main environmental health problems may be those associated with the rainy, dry or harmattan seasons such as variety of general body aches and pains - backache (Giwan baya), shoulder pains (Giwan kafafade); aching joints (Sanyi jiki) etc. Some boils, skin rashes are caused by environmental condition of cold weather as well as sore throats. In extreme cold temperatures, Hausa mothers must observe strict post-partum regimen of confinement, hot baths and a special diet. Heat (Rana) spoils people's

blood, causes tension headaches, body dehydration through profound sweating, general body tiredness or weakness. The dry season carries with it high temperatures which are excessive in several Hausa regions.

In certain situations some zoological or other hazards can be quite frequent and fatal in Hausa land especially from such poisonous creatures like scorpions, snakes, blister beetles, hair lice, jigger, rabies, worms, mosquitos etc.

Equally, some sections or areas of Hausa environments must be avoided. Among these are such places like graveyards, some doorways, evil forests, shades of some spirit-inhabited trees, some river valleys, some upland areas. The river valleys, for example are believed to be the homes where malaria (jante), leprosy (mayauya), sleeping sickness (cutar barci) can spread and can be contracted very quickly. The highland areas on the other hand, are believed to help spread of scabies (k'azwa) more quickly.

Good behaviour to Hausa people means that an individual must strive not to violate the norms of Hausa society. The health of an individual depends upon how far he goes to observing these norms. The use of illegal and harmful drugs, cannabis, marijuana, alcoholic drinks etc are all un-Islam and must be avoided. Koran should not be used to swear false oaths. Sexual intercourse must be avoided until the baby is weaned. Over consumption of sweet foods, especially sugar can upset stomach and can be fatal.

There is a deep fear amongst the Hausa people that witchcraft is also associated with black magic. Witches claim souls unjustifiably and this by

itself increases peoples' fear and drives them to consult those traditional doctors who are capable of recommending some active anti-witchcraft medicines. In addition, charms may be worn in certain situations or cases to ward off witches before any harm is done by the witches. Witches are believed to be responsible for some internal body pains, bleeding from a body orifice and the steady wasting away of chronically ill persons.

An Hausa traditionally believes that witches can also be seen or noticed from the way evil people (witches) look at others with their evil eyes (magun ido) or from the bad language (magun baki) which these evil people (witches) often use. These malevolent people according to Royan (1974) have the power to make others ill; this illness being imposed by the witches by means of their wicked staring or through their bad language. This sort of spirit-caused illness can be sudden and sometimes recognised by their exhibition of multiple and difficult symptoms, sometimes accompanied also by excessive vomiting, extreme fevers, convulsions by children or infertility-related health problems, (e.g. suspended pregnancy etc), infant mortality, mental disorders etc.

1.1.2 The Ibo Profile

The map of Nigeria shows Ibo land covering the South-Eastern part of Nigeria between latitudes 4° and 7° North and between longitudes 6° and $8\frac{1}{2}^{\circ}$ East with some 15,800 square miles of the area being occupied by the Ibos. According to Meek (1937) the Ibos historically have no tribal history: "Their only form of history is purely local traditions of the various communes or village-groups. As far back as we can see within historic times the bulk of the Ibo people appear to have lived an isolated

existence". This view was not totally different from the anthropological claims by Ford and Jones (1950) that the Ibos, before the colonial adventure of the Europeans (British), had no common name and village groups were commonly known by their putative ancestral founders' names: Port Harcourt, Bonny etc. Some other writers, for example, Jeffreys (1946) claims that the word Ibo had a real connotation that meant 'Forest Dwellers' but others like Ford and Jones (op. cit) believe that the word Ibo emerged from a different source in connection with a distinguished historical event of slavery, believing that during the era of trans-atlantic slave trade across Africa, the local Ibo dealers in the East Coast of Nigeria which included the Riverine populations of Bonny, Opopo etc first used the word Ibo as a way of describing the non-Riverine Ibo populations, that is, the Ibo mainland settlers amongst whom slaves were either captured or voluntarily given away or sold by the local dealers to European slave merchants on the coasts of the Riverine areas. The Ibos were also known to speak one common language but with some local dialectical variations from which was developed what Chukwuma (1974), referred to as 'Central Igbo' dialects. The Igbo language in turn became the dominating language amongst others spoken in the whole Ibo land: Anambra State, Imo State, some parts of the Rivers State and some regions of the Bendel State.

The climatic characteristics of Ibo land show an average annual temperature of over 80°F in the dry season. There are much of the heavy rain storms taking place in the rainy season with over 70 inches of rain per year.

Agriculturally, the Ibo people work on their farms to grow food crops while local fishermen catch fish in the areas with rivers and oceans. Cashew

nuts, peanuts, oil palm kernel are produced locally for local consumption as well as cash crops while yam, coco-yam, cassava are the tubers grown as staples. There are other commercial activities and private businesses in which the Ibos feature prominently especially in retail or distributive sales. The Ibo people are known to be very enterprising, industrious and ambitious and this has made them very acceptable to the early European missionaries and colonial offices who engaged them in domestic duties and portering services and other menial jobs.

The Ibo political structure traditionally does not recognise any one particular person as the King of the Ibos, hence the Ibo people do not have kings to rule them (Igbo enwe eze). This universal agreement amongst the Ibos that they do not wish to have any kings is constitutionally acceptable to both old and new generations. Culturally the Ibos are known to be organised and govern themselves in small but competent village committees or groups, a system of traditional government which Meek (1937) had described by saying: "The most characteristic feature of Ibo society is the almost complete absence of any higher political or social unit than the Commune or small group of Contiguous Villages, whose customs and cults are identical, who in former times took common action against an external enemy - though they frequently also fought amongst themselves - and whose sense of solidarity is so strong that they regard themselves as descendants of a common ancestor."

In his description of Ibo village groups or committees, Uchendu (1965) added fresh views to some of Meek's claims. Uchendu believes that amongst the Ibos, "Government at the village level is an exercise in direct democracy. It involves all the lineages and requires the political

participation of all the male adults. Though it forms part of the village group, the widest political community, the village is autonomous in its affairs and accepts no interference or dictation from any other group."

The traditional methods of rule in Ibo land is thus a big contrast to those of the Hausa people as the Ibos do not have traditional rulers like the Emirs and Sultans of the Hausas. The Onitsha people being Ibos also tend to have what they call 'the Obi of Onitsha' which is only a local kinship which the Onitsha Ibos inherited from part of culture that originated from Benin in the Bendel State where a long established 'Oba of Benin' monarchy ruled. Benin City is a medieval city in which Oba title and rule is inherited while the 'Obi of Onitsha' is electively chosen by Onitsha people on competitive basis. The Obi of Onitsha has no influence over local or state or national government affairs, unlike the traditional rulers of the Obas, Emirs or the Sultans who are recognised traditional leaders.

Religion plays an important social and spiritual role for the Ibos. They also have a traditional tribal religion which is shared by all members and in matters of religious participation, the most effective unit of religious worship is the extended family. Therefore the Ibo traditional religion is polytheistically oriented. The notion that God is the creator of all things is the main theme guiding the actions of the Ibos. The Ibos also believe strongly that their supreme God is 'Chineke' or 'Chi-okike' meaning God of Creation who also gives a pivotal support to heavens, which gives him what the Ibos call 'Agalaba ji igwe'. It is the Ibo belief that sky is the paradise where this God lives and Ibos normally address this God as God who lives above or in heaven, which in Ibo means 'Chi di nelu'. Generally this Supreme God is recognised as the most powerful amongst the rest of other gods

which are known to be minor and hence is called by the name 'Chukwu' which means 'Great or High God'. The minor gods are also worshipped by great number of the Ibos as these gods are also believed to perform some specific functions in the lives of the Ibos. The goddess of land (Ala) which is responsible for soil fertility and that of human beings is highly recognised in some parts of Ibo land. The sun-god is equally respected and worshipped. The Ibos call this sun-god 'Anyanwu' which is responsible for the growth of crops, plants, shrubs, trees etc. The sun-god is also very much feared as it can be invoked in the form of what the Ibos call 'Amadioha' or the spirits of lightening. Amongst several Ibo villages, some man-made oracles have been created to represent the sun-god in the form of oracles officially named 'Amadioha'. 'Igwe' the god of sky which induces rain is not symbolically represented artificially but is known to be much larger than earth in comparison and this is why the Ibos refer to it as 'igwe ka ala'.

Many other minor gods are recognised and worshipped by majority of Ibo people. Such minor gods can be associated with, for example, rivers which sometimes claim people's lives through drowning. The Ibos believe that if one does drown, he or she must be buried at the banks of such rivers to make peace with the deities that live and own such rivers, but more than this, to stop any further loss of life through drowning. On such occasions too, no special burial ceremonies or rituals are performed for those who drown in these rivers.

The Ibo people also pursue wealth relentlessly and believe that one's prosperity does not depend upon his ability and luck only but also, largely determined by the gods and spirits of wealth who must be worshipped with

chicks, sacrifices, ceremonies, kola nuts, alcoholic drinks to ask for improvement in one's chances of success or conversely to appease them for what has been done wrongly which brought misfortune or catastrophe to one's business paths and undertakings.

In several other towns and villages in Ibo land there are many powerful shrines which Ottenberg (1958) calls the 'Oracles of Ibo land'. They include Oracles that have existed for generations such as 'Agbara' of Awka; the 'Igwe' of Umunoha; the 'Amadioha' of Ozuzu; the 'Ibini-Okpabe' of Arochuku etc. It is believed generally that these oracles are so powerful that they serve a supreme judicial role to which final Court of Appeal should be made amongst Ibo traditional communities, especially when local disputes or disagreements arise. The local people also believe very strongly that if one is found guilty in the judicial process involving these oracles, the person is penalised or condemned to death. Although majority of the Ibos are also christians, it is known that church attendance should not be used as criterion for true christian acceptance. The Ibos tend to say that true christianity is in one's heart 'Uka di nobi'. To some people, christianity is seen as foreign religion imported from whiteman's land and hence accorded a low theological status. Even when people claim that they are christians, they still tend to worship gods and idols at the same time.

Many Ibo christians are frequently known to indulge in some non-christian festivities and ceremonies involving local sacrifices. There is also the prominent activity in Ibo land which attracts the collaborations of both the christians and non-christians called 'ichi ozo' in which a local title is taken to mark one's distinct qualities and achievements amongst other local people. Such an occasion is marked with merriment and local sacrifices to

spirits of ancestors and their gods. When christians take part in 'ichi ozo' title, it is stressed (Ottenberg ibid, Uchendu op. cit) that they do so secretly. This is because church leaders and officials have frequently argued in Ibo land that christians should have nothing to do with such ceremonies and sometimes those who deferred the warnings of the church tended to be suspended or dismissed from the church membership.

It is widely believed that the socio-cultural activities of the Ibos, their traditional beliefs, and traditional political system are reflected in their general attitudes to life as described by Uchendu (ibid) who summarises that: "The Ibo lay a great emphasis on individual achievement and initiative. There are no restraints, human, cultural, or supernatural, which cannot, theoretically be overcome. Ibo individualism is not rugged individualism; it is individualism rooted in group solidarity. The traditional government is a direct democracy in which leadership is achieved on a competitive basis. It is ability rather than age that qualifies for leadership, an important ideological factor is the Ibo ideas about change. The Ibo believe that change is necessary for the realisation of their long-term goals."

Health Behaviour of Ibo

There is a general consensus amongst the Ibos that 'Ndubisi' (Health comes first) or 'Ndubu Aku' (Health is wealth). Achebe (1961) described Unoka's ideas about life and death: Unoka believes that if people see the mouth of a dead person, they will waste no time in realising or seeing the folly of one not eating what one has in one's lifetime. Many Ibo people also tend to proclaim the Epicurian philosophy - eat and be merry for tomorrow you may die, but they also believe in a systematic planning for the future.

Death is the ultimate end of life and life itself is constantly under threat by death through ill-health. This is why Ibos answer many ancient but traditional names that bear special plea or warning to death, for example, 'Ozoemena' means 'Let it (death) not happen again'; 'Onwumbiko' mean 'Death I implore you' or 'Death please don't harm me'; 'Onwurna' means 'Death knows'; etc.

The cultural beliefs of Ibo people make them to believe in 'Ogbanje' (false or artificial babies who only live for the shortest period of time and die, only to re-enter the womb for the second/third/fourth times) etc. 'Ogbanje' is also believed to be a wicked child who really does not want to stay or live but to torment its mother endlessly. Many Ibos claim that 'Ogbanje' is always receiving instructions from their evil spirits as when to re-enter or leave the mother's womb. There is no easy way of believing or accepting the facts that cause high infant mortality as the modern health care of babies has always not been accepted. The traditional doctors tend to recommend some animal and vegetable traditional mixtures and medicines to stop the repeated births and disappearances of 'Ogbanje' and also they tend to recommend the cremation of such babies to stop them returning back to their mothers' wombs again to do some harm.

'Ekwensu' is evil spirits that can easily enter into people's eyes and make them to behave abnormally. They may look fierce, tense and wicked. Under such tensed atmosphere, 'Ekwensu' can be very destructive once they have used a person to their advantage, either to kill people once in a crazy mood or commit other atrocities and barbaric acts, to which there may be a remorse soon afterwards, when everything must have gone wrong. It is

believed that certain people can be self-controlled when 'Ekwensu' are inside their heads or eyes.

'Afo Otuto' is believed to be an abomination to earth's bowel. 'Afo Otuto' is the swelling in the stomach or the inflammation of stomach which the earth goddess will not want to accept its victim for burial. In the ancient Ibo villages, people who were to die from 'Afo Otuto' were simply taken away to Evil forest (Aja Ohia) to die and rot away without any proper burial or funeral ceremonies. Witches and wizards are widely feared amongst Ibo populations. 'Amosu' the witch has supernatural powers and can kill wrongly or rightly. It can be hired to kill also. Malevolent elderly women tend to be known as the most dangerous Amosu, although old men can also practise witchcraft and indeed, witches may disguise themselves as cats, owls etc. 'Dibia Amosu' are the witch doctors who go to a great length to help the Amosu victims out, as some of them at some stage of their life have been either involved in the game itself but now renounced or simply known what to do to avoid or cure such health problems associated with witchcraft.

There are diseases that are very common in Ibo land that may be treated with traditional or modern therapies or both and these include:

1. 'Otoro' (Cholera)
2. 'Oro-Ura' (Sleeping Sickness)
3. 'Ekpe-Nta' (Leprosy)
4. 'Ogba-Agwa' (Measles)
5. 'Ukwara-Nta' (Tuberculosis)
6. 'Afo-Osusa' (Diarrhoea)

7. 'Ukwara' (Cough)
8. 'Ume-Ngwu' (Chronic laziness)
9. 'Aga' (Barrenness)
10. 'Kwashiorkor' (Malnutrition) etc.

1.1.3 The Yoruba Profile

The Yoruba people have a strong sense of continuity between the past and present: "The good will of their ancestors must be sought or the best laid plans will come to nought, their prescence permeates family compounds, and sacred shrines, and may at times descend upon living men and women who are in a suitably receptive state of trance" (Maclean, 1974).

The oldest strands of Yoruba gods are many but their traces of earth worship originated from the 'Ogboni Secret Society' while 'Shopanna' is their god who is claimed to be responsible for any outbreak of epidemics of small-pox and who has power to promote earth's fertility, successful sowing of seeds and harvests.

In Yoruba communities, any sudden death or attack from unknown sources arouses fears about witches and their wicked deeds. The power of witches and their pervasive influence is continually felt in a majority of Yoruba communities. Consequently the role of Yoruba native doctors are highly accepted in these rural communities because of their healing powers against witchcraft-related health problems. These Yoruba native doctors associate themselves frequently with the 'Ifa Oracular system in which diviner priests known as 'Babalawo' can forecast or interpret the intentions of gods, evil men or the wishes of ancestors. The 'Ifa Oracular System'

itself is achieved by recording the results of loosely throwing some of a handful of 16 kola nuts from right to left hand. The success of this system depends upon whether an odd or an even number of the kola nuts remains in the right hand after the throw, a single or double mark is made upon a sand covered tray. The wooden 'Ifa tray', is often elaborately carved, and bears sets of marks in a double column. As a rule of the 'Ifa Oracular System', the 16 kola nuts are cast 16 times and the outcome of each set of four throws is noted in terms of the result and pattern of single and double strokes upon the tray. The 'Ifa Oracular System' is completed when 'Babalawo' - the diviner priest interprets the contents of the oracle forecasts, decisions or demands for each inquirer or client and solemnly pronounces the results of his divination and then offers some advice as to what appropriate action should be taken by the client.

The oracle itself may indicate that some local sacrifices should be made by the client to his ancestors or gods or it may suggest that the client become an adherent of some cult other than his family's cult whose god may have been judged or proven to be unsuitable to his personality. The oracle may equally inform the client about disturbed relationships within his family and the need to restore good feelings between his relatives.

Amongst the Yorubas, any serious illness is believed to be only one out of many possible misfortunes which may befall someone. The 'Babalawo' is not only capable of finding out the causes of such serious illnesses or misfortunes but also the causes of other personal disasters and in many cases, the causes are always associated with spiritual influences emanating from the dead, from the gods or from the living and require appropriate rituals to counteract or appease them.

The Yoruba people are naturally very superstitious. Their superstitious beliefs tend to arise from ordinary daily events. If, for example, a Yoruba palm-wine tapper was unaware that a frayed rope was involved in his misfortune to fall from a palm-tree, this accident will not prevent his wondering why it should have happened to him in particular, on that very day, up that particular palm-tree, and the demonstration that his rope must have been in decrepit condition will not satisfy his search for the real, underlying cause of his accident. Similarly, if a Yoruba folk catches a cold which tends not to respond to medication within a reasonable period of time which an ordinary cold is expected but rather is aggravated further by signs of wasting and general debility, the Yoruba patient would prefer to look for a deeper cause by consulting a native doctor.

Any personal ill is claimed to operate through curses elaborately prepared and delivered, or through the manipulation of various magical devices which enable hatred and envy to act effectively across time and space. But none of the individual operations of malice in Yoruba land are feared as much as the Yoruba witches. Impotence in men, infertility in women, disorders of the reproductive system; venereal diseases etc may be caused by several other reasons but the most likely underlying cause is always associated with the Yoruba elderly women who are known to derive their powers as witches from 'Eshu' shrine. The subject of witchcraft is bound up with Yoruba ideas that the soul or spirit leaves the body during sleep and travels to meet others. Witches then gather secretly at night for cannibalistic feasts and orgies. Or a witch may fly alone into her victim's house where she seduces him or her with sexual dreams, leaving him or her weak and flaccid, or prey to fears, wasting fevers etc. She may at time

harm someone's health or fortunes directly or she may choose to damage another woman's child, causing the child to fall sick and die.

The owl is believed to be the witch bird. To hear its hooting voice at night or have it perch near one's home suggests omen or bad luck for the person. Iroko trees and the baobab trees are believed to be the favourable meeting places for witches. Owl is not the only symbol which represents a witch; cats, bats, and even house mice are claimed sometimes to be witches in disguise and must be suspiciously watched and whenever possible killed.

The Yoruba native doctors, herbalists and diviners are always available for consultation as they must professionally consider or examine a particular health problem or bad luck of any individual and say whether witches have had a part in causing the health problem or misfortune, especially, if in the case of health problem, it is established that the problem is failing to respond to Yoruba traditional or conventional forms of treatment. The traditional healers may extend their enquiries to discover the extent of witch involvement or 'Orisha' the ancient Yoruba pantheon gods or even the 'Olodumare' the sky god of 'Shango' responsible for thunder victims. There is a strong belief that 'Abiku' (children who are born to die) do a lot of harm to their mothers, knowing very well that they only have to live for the shortest period of their infancy before rejoining their spiritual companions who have urged them to return. The Yorubas fear and rebuke such children without mourning for them as would be the case for any normal baby or child who happens to die in his or her infancy. Following the uncertainties surrounding 'Abiku's' life and how long it intends to live or stay with its mother, the majority of Yorubas in collaboration with some Yoruba professional native doctors in Abiku, invent some names which the newly

born babies must answer which symbolise a plea to Abiku itself or merely as an anti-Abiku remedy: 'Malomo' means 'Do not go again'; 'Banjoko' means 'Sit down and stay with us'; 'Duro oro ike' means 'wait and see how you will be petted'; etc. The baby then grows with this type of name and as it grows, it is also plied with specially tempting foods and feasts and children celebrations to entice, please or keep it very happy so as not to become Abiku to leave its mother heartbroken again. The native doctors would recommend and prepare amulets to be worn around the baby's small waists, wrist and ankles to stop or fight off any evil intentions from Abiku and its spiritual playmates.

The traditional therapy for guinea worm infestation in Yoruba land is remarkable also. This starts with a ring made from the bark of 'Olorin' tree or 'Eru' tree. Nine are then made with the rope while another rope is cut into pieces to be mixed with some white beans and some ground-whip hide. A snail is then put in to the mixture and this is cooked altogether without water. The cooked (dried) snail is then eaten almost as soon, but the beans are ground and mixed with a shea butter which must be applied to any sores. The remaining beans are eaten gradually while the knotted string is used to rub the whole body of the patient after which this knotted string is inserted into the snail shell. The patient's wrists and ankles are tied with white threads before the snail shell is buried and this means the end of the guinea worm soon after this incantation is uttered by the patient in the process of burying the snail shell:

'I bury the dead of the guinea worm in my body, let it never attack me again, because the dead never rise into the world again'.

It is also believed that the Yorubas have many other ways of effecting a cure of an illness which may have similar elaborate processes like traditional therapy for guinea worm and these traditional means of curing illnesses are used to solve health problems that are common in their local communities, including dizziness, high body temperature, headache, eye disease etc. The native doctors can also prescribe certain traditional drugs for retentive memory and easy understanding, or to make an evil deed towards you recoil to the person who initiated it. This boomerang principle in cursing is particularly popular amongst the Yoruba native doctors from Ijebu which is a rural village some few miles away from Lagos, Nigeria. The Yoruba native doctors and the Ijebu native doctors in particular, are believed to have easy remedies/medicines for conquering enemies, for ear trouble, cholera, stomach ache after birth, medicine to make a woman productive, medicine for safe journeys, incantation to drive away lunatics, incantation for gonorrhoea, medicine for rapid sales and quick profits, medicines for malaria etc.

1.1.4 Elementary needs of Nigerian people

1. HEALTH

The overall features of development take on their human characteristics when one considers the satisfaction of elementary needs of the Ibos, Hausas, Yorubas and indeed the whole of Nigeria. Three major areas are important: health, housing and education.

In health, there is some cause for hope as well as concern as most people in Nigeria are living much longer today than they were two decades ago. But it is equally true that life expectancy is still very low, the average being

about 45 years. The elimination of small-pox was one of the triumphs of the 1970s in which Nigerian people benefited. Many communicable diseases of cholera and malaria are being controlled, although malaria still remains the single biggest killer. Some local health authorities, health centres and clinics function for health improvement of Nigerians but are still running into the more intractable conditions of poverty and malnutrition, poor hygiene and sanitation, all in turn contributing to high infant and child mortality. Lack of safe water is a major cause of ill-health, as virtually half the Nigerian water supplies are uncertain. Four out of five people living in Nigerian land rural areas do not have reasonable access to even relatively unpolluted water. In countryside, women have to cross long distances to fetch water, firewood etc, the minimum requirements that must daily be secured for their families. Bad sanitation has remained a long lasting problem in several villages causing numerous water-borne diseases. Often sick village people transmit disease in faeces, worm eggs, amoebic cysts, virus or bacteria pass into drinking water to be drunk by an uninfected person. Similarly diseases pass from faeces, urine or skin into uninfected persons through water dwelling animals such as snails. Insects are mainly found near water also where they breed and transmit disease when they bite people. Deaths frequently occur from diarrhoea caught from polluted water.

Improving health for Nigerian people requires efforts far beyond medical care; it is to be closely linked with food and nutrition, with employment and income distribution. But there are a number of priorities within the health sector itself - the Nigerians really need adequate provision of basic health facilities and basic health care provisions to permit them to lead a socially and economically productive life. This means raising health

services to an acceptable level for them, immunizing every newborn child against most common childhood diseases, providing primary health care for all, providing clean water and sanitation, greater political determination to reform orthodox medical systems and to encourage Nigerian co-operative community activities and for improvement of primary health care generally.

2. HOUSING

The need for housing for Ibo people as well as other Nigerians is fundamental. But the state and local government administrations tend not to give it priority and the individual is commonly left to fend for himself, even though in majority of cases, poor villagers could not afford to house themselves adequately. The rush of the young people to cities (Enugu, Aba, Port Harcourt, Onitsha, Benin etc) has created additional misery to the elderly who are left behind in the villages with nobody to look after them.

The Nigerian oilboom and industrialisation were labour-intensive which made Ibo cities to grow as jobs expanded but when the economy collapsed, migration from Ibo villages continued still due to lack of job opportunities in the countryside. Even today migration is still rural push as much as urban pull. The consequences of high birth rates and rapid migration of all too visible at Enugu, Port Harcourt, Onitsha, Aba, Benin and other cities, with abysmal living conditions and very high unemployment or underemployment. The strains on families, are very heavy. The old people tend to die as a result of lack of care but not loneliness.

It is observed that for many generations, the Nigerians strongly believe that when an individual is sick, medical care must be sought. The tendency

for traditional care or modern health care to be chosen entirely depends upon the type of health problems that have arisen. However, communities at village level tend to favour traditional remedies to modern therapies, simply because the native doctors are not only available and accessible, but also cheaper in terms of financial costs for consultation or treatment or both. But equally, in several other Nigerian villages today, a wider acceptance of the role of health centres and clinics is being recognised and on the increase. Consequently, there is a growing concern that both traditional medicine and modern medicine could be allowed to co-exist if proper research is done on how best to achieve this without harming patients. Conversely, it is felt that this may lead to some form of rivalry between health practitioners - both modern and traditional alike. Already these two are claimed to be doing just that, and this has led to many of the Nigerians to have some rudimentary knowledge of the kind of remedies these practitioners apply to cure some of the common illnesses in several Nigerian communities.

B. PHC MANAGEMENT IN NIGERIA

Primary Health care initiation and development in rural Nigeria requires some research into some existing and future management activities and management practices in the Nigerian PHC systems. Management is therefore an essential component in an effective programme of primary health care but this should not be understood in term of imposing management structures based on Western management theories which are inappropriate for the culture and socio-economic status of Nigeria. Primary Health Care management systems in Nigeria should be designed to produce results that are adaptable to Nigeria's health needs and its socio-economic circumstances and aspirations.

1.1 PHC DEFINITIONS

The Alma-Ata Conference Joint Report for WHO and UNICEF (1978) defines PHC as "essential health care based on practical, scientifically sound and socially accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford, to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both of the country's health system of which it is the central function and main focus of the overall social and economic development of the community. It is the first level of contact of individuals the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process".

PHC is now a field bedevilled by controversy as to what is its acceptable definition as the following selection of definitions would indicate:

- i) Jonas (1973) in his review of PHC presented the definitions of ten different authors and these range from Cohen's succinct: "What everybody needs and can't get", to the hundred word effort from the Pellegrine Committee.
- ii) Fendell (1977) claims that PHC is by no means a new concept and that the new phraseology or jargon embodied what used to be called Basic Health Care, rendering to the needs of the family in its home and village environment for its simple everyday wants in medical and health care, a system which seeks to integrate or co-ordinate a simplified health delivery system.

Many other writers have provided some useful thoughts or ideas towards understanding the notion of PHC:

- i) Hammad (1978) described the term as being mainly concerned with the health and well-being of the people as an approach which aims at meeting the priority needs and satisfying the needs".
- ii) Millis (1970) stressed the important distinction in meaning between the words 'care' and 'cure' - the important difference according to him, is that 'care' is process while 'cure' is episodic.
- iii) White (1967), Haggerty (1969) and Rogatz et al (1970) have all referred to PHC as first or initial contact care, claiming that the

word primary conveys the notion of first, as in a series of sequence, but it also conveys the notion of basic, as in the fundamental elements of a whole.

Benyousseff and Christian (1977) summarised the state of Health Care in developing countries and the emerging responses in the form of PHC : the very term 'delivery of health services' is no longer strictly correct, as it implies something delivered to people from above or centrally, whereas the concept gaining acceptance is the health services generated within the periphery and linking up with a referral system.

In Britain the term PHC was used in 1962 to denote general practice and has since achieved wider prominence in this direction as reported by White (1963; 1964). Abel-Smith (1976) described PHC as being planned in some countries to secure a number of different aims, including to secure that groups of primary care doctors work together in co-operation rather than competition to serve the needs of their local community.

1.2 THE BASIC HEALTH CARE ADMINISTRATION IN NIGERIA

Primary Health Care services are offered to people in Nigeria at the point of entry into the Health Care System. In many Nigerian states, basic health care provision with participation of some village community workers and health auxiliaries is provided at health centres, clinics, maternity homes and rural hospitals. The management of these basic health services varies from state to state. In some states, the state Ministries of Health are directly responsible for providing such services while in others such responsibilities have been delegated to Local Government Health

Authorities. In either case, the basic health units (Health Centre, Clinic etc) are conceived as basic health facilities to provide some integrated, comprehensive and easily accessible basic health care for the people living in the rural communities. These basic health facilities provide basic health care including medical care, maternal and child health, family planning, communicable disease control, hygiene and sanitation, nutrition, health education, dental health, school health etc.

In Nigeria as a whole, primary health care is the most important aspect of health care system being itself, the first point of contact for most patients and also usually the only available health care for some people, especially those living in the periphery and rural villages.

In some of the states where these basic health units are well equipped, their functions are wide ranging, for example, they offer:

1. Treatment of simple diseases and short illnesses by out-patient care.
2. Participation in immunization and community health and nutrition programmes, including control scheme for communicable diseases.
3. Maternal and child health work etc., including ante-natal examinations, health education to mothers, delivery facilities to under five clinics.
4. Rural sanitary facilities to provide continuous service for health education, particularly those for environmental health and hygiene.

5. A limited in-patient service facilities for acute illnesses of short periods where only a relatively few beds are provided such as the comprehensive health centres before referring the patient to secondary health facilities.

The health workers that work in these basic health units are involved in one or several activities going on in and outside these health centres, clinics, maternity homes etc and in addition:

1. Spend time searching for improvement in local water supplies and are actively involved in discussions with communities on health improvement programmes.
2. Are involved in disease surveys and collection of accurate statistics.
3. Build up a complete picture of the living conditions, customs, ideas etc about life in the rural communities.
4. Help to put into practice whole aspects of environmental sanitation with constant support of the villagers.
5. Provide school health service in the village communities.
6. Offer practical suggestions to senior health managers on how to mount effective local and national immunization campaigns, including satisfactory transport and communication infrastructure, agriculture and food production, socio-economic improvements etc in the rural areas in order to improve quality of life and reduce disease and deaths and poor health generally.
7. Private, Industrial, Mission etc Hospitals: Health care is also being provided, controlled and managed by some missionaries, industrial establishments, private individuals etc and methods and

styles of management are as varied as there are private health establishments. With a few exceptions, the overriding aims are to maximise profits and stay in business.

1.3 ORGANISATIONAL ARRANGEMENT FOR PRIMARY HEALTH CARE IN THE MINISTRIES OF HEALTH, NIGERIA

The broad lines for the development of Primary Health Care in Nigeria are contained and defined in the 'Nigerian Basic Health Services Scheme' document (NBHSS). The NBHSS document was primarily concerned with the basic health needs of large sections of Nigerian population and the desire to extend health services to the remotest rural areas. It emphasised the need to develop approaches to improving health status of individual citizens which is not over-dependent on expensive forms of health services.

The document advocates that Nigerian governments should develop national, regional and local government policies in Primary Health Care which seek self-reliance in community and general development, placing greater emphasis on development and use of resources in the rural communities and peripheral areas, where traditional forms of decision-making and co-operative efforts must be encouraged in all PHC activities.

The (NBHSS) document urges that all the governments - Federal, State, Local Government - must have an early awareness that community involvement in primary health care activities require a broad intersectoral approach (education, agriculture etc) for two main reasons:

- i) Community priorities are the starting point for mobilisation of local resources in addressing health and socio-economic problems, not just priorities restricted to health sector alone; and
- ii) Improvements in health conditions are best viewed in relation to improvement in general, social and economic development. This requires government services and personnel in agriculture, community development and social welfare, education, water supply, roads and transport and administration as well as health sector are involved in PHC activities.

The NBHSS document also places greater emphasis on effective Primary Health Care Management at three different levels:

- The Local or Operation level.
- State Ministry of Health or Intermediate level.
- Federal Ministry of Health level.

THE LOCAL OR OPERATING LEVEL MANAGEMENT is primarily executive in nature and covers the numerous managerial functions in clinics, dispensaries, laboratories, village health posts etc. Local operation planning, resource utilisation, routine administrative tasks, co-ordination and evaluation etc may occur at this level.

STATE OR INTERMEDIATE LEVEL MANAGEMENT is concerned with the interpretation of policies and plans and the development of programmes for the implementation of the national plans. The

vital tasks of co-ordination between national and operating levels and evaluation of the effectiveness of technical aspects of primary health services are also to be performed at this level.

NATIONAL LEVEL MANAGEMENT has broad federal jurisdiction and concerned with policy-making, long-term planning and programming, establishment of national norms and standards, and corporate co-ordination and evaluation of primary health care services.

The PHC management functions and activities at every one of these levels are different but the overall goal is to make PHC effective throughout the country. These Primary Health Care Management functions and activities at each level may be stated thus:

THE LOCAL OR OPERATION LEVEL:

1. Management activities to be performed by those who fall outside the main stream of organised health system in Nigeria, namely, leaders of Voluntary Agencies, Religious Groups, Women's Organisation, Trade Union Groups etc would include:
 - i To create awareness within the community of the meaning of HFA/2000 and role of PHC.
 - ii To organise the community for participation in health development.

- iii To collect, analyse data and identify health problems.
- iv To co-ordinate logistical support for PHC services.
- v To provide feedback on effect of PHC services.

2. Management activities to be performed by those who work formally within the organised health system, namely managers of maternity homes, health centres, dispensaries (clinics), Primary Health Care Teams, specialised teams etc would include:

- i To plan local health programmes.
- ii To manage the implementation of local programmes.
- iii To promote community health organisation.
- iv To co-ordinate inter-play agency programmes and liaise with intermediate level health services.
- v To monitor, control and evaluate performance at local level.

STATE MINISTRY OF HEALTH OR INTERMEDIATE LEVEL:

1. PHC Managers at this level would serve the link between national and local levels and perform the following management activities:

- i Consolidation of plans and formulation of regional policies and programmes.
- ii Design and operation of a wide referral system throughout the state.
- iii Adaption and transmission of organisational plans and directives for management of health services including collaboration with other sectors.
- iv Adaption and definition of norms and standards pertaining to the provision of health care services and administrative systems and procedures in the state.
- v Monitoring and evaluation of progress and performance of programmes in the state.

NATIONAL OR CENTRAL: FEDERAL MINISTRY OF HEALTH:

- 1. The PHC policy-makers, planners and programme managers at national level would be broadly engaged in the following activities:
 - i Assisting health policy-makers - ministers and senior politicians in formulating broad policy guidelines on major health issues and programmes.

- ii Long-term national planning and programming of health services to implement the government health policies.
- iii Mobilisation of political will and public opinion and support.
- iv Negotiating, obtaining and allocating resources at national level - materials, manpower and money.
- v Setting national norms and standards and monitoring and evaluating progress and performance.

The NBHSS document stresses that for these PHC management functions to be performed efficiently, some relevant health management training should be required at each level and this health management training, amongst other things, must:

- i) be need/task oriented
- ii) enhance effective delivery of health services
- iii) lead to making optimal use of resources
- iv) enable more objective and rational decision-making and priority setting
- v) lead to clearer definition of health objectives and goals
- vi) be appropriate in terms of needs, technology and socio-economic environment of Nigeria
- vii) result in reducing wastages, mis-use and delays in the system
- viii) lead to balanced coverage of health services

- ix) increase greater public participation
- x) lead to efficient performance of clinical and administrative tasks.

This Primary Health Care management training at each level, must also

- i) cater, in a balanced form, for all levels of health workers
- ii) lead to balanced development of knowledge, skills and attitudes
- iii) be of right duration
- iv) have proper mix of conceptual and practical learning
- v) use most effective teaching/learning material and methods
- vi) have the right type and amount of training facilities
- vii) have sound resource personnel to effectively plan and deliver the programme.

1.4 THE NIGERIAN BASIC HEALTH SERVICES SCHEME (NBHSS)

The implementation of Nigerian Basic Health Services scheme as contained in the NBHSS document and Third National Development Plan started in 1976 as the surest practical pathway towards the achievement of health for all by the year 2000. Under this scheme, the teaching hospital boards have to provide for PHC, specialist services and clinical teaching facilities for medical students and other personnel. Joint committees were set up in the scheme to be able to evaluate health care services periodically as they are being provided by different health institutions. The scheme placed special emphasis on preventive care.

The scheme involved the establishment of 285 Basic Health Units throughout the federation; each basic health unit providing health care

services for 150,000 people. The components of each basic health unit include:

- i) 1 comprehensive health centre with 30 beds to cater for 50,000 people
- ii) 4 primary health centres; each having 14 beds to serve 10,000 people
- iii) 20 health clinics; each has to serve 2,000 people
- iv) 5 mobile teams attached to health centres and capable of serving 4,000 people each.

Rural and underserved areas of the country have been given special consideration and priority in the implementation of the basic health scheme.

Objectives: The main objectives of the basic health scheme have been stated as follows:

- i) To extend health services in stages to every Nigerian by 1990, irrespective of his place of abode. The scheme set itself two main targets in this respect - to achieve a minimum coverage of 40% by 1980 and to achieve a 100% coverage by 1990's.
- ii) To correct imbalance in service distribution and location between rural and urban areas.
- iii) To emphasise and promote preventive health as opposed to curative.

- iv) To provide a comprehensive and well-integrated health service system for the country by providing the necessary infrastructures and co-ordinating their activities.

In order to meet these objectives, the scheme requires the Basic Health Units to perform the following functions:

1. Environmental Health Services
2. Family Health Services: Maternity care, Child care, Family advice
3. Health Education
4. School Health Services
5. Control of Communicable Diseases
6. Health Statistics
7. Community Health Services: Nursing, mid-wifery, social care
8. Dental Health Services
9. Mental Health Services
10. Occupational Health Services
11. Medical and Emergency Services
12. Basic Health Service Administration.

The basic health unit is made up of health clinic, the primary health centre, the comprehensive health centre and mobile clinics and their functions include:

A. The health clinic functions

The health clinic has preventive and curative function at village level and also to diagnose and treat common illnesses; recognise and refer cases of serious illness to higher level; carry out vaccinations in conjunction with rural health centre team; pre-natal and post-natal care to high risk cases; advice and referral for child spacing on health grounds on request; health education supervision, training and supply of UNICEF equipment and supplies to traditional birth attendants; passive case findings and treatment; report to rural health centre of any outbreak of communicable diseases.

B. The Primary Health Centre

In addition to its functions in connection with health education, protection, restoration and rehabilitation, primary health centre also has to diagnose and treat referral cases from health clinics; provide and carry out routine mass immunization, provide ante-natal and post-natal care; provide family health services; supervise health clinics, provide dental health care. Fundamental to the role of the health centre are the principles of PHC (WHO 1975); emphasis on team work (Hastings 1972); the process of referral (Tonkin, 1976) and the growing acceptance of the use of medical auxiliaries (Backett 1975).

C. The Comprehensive Health Centre

The comprehensive health centre has to deal with health problems with some degree of sophistication which the primary health centre or health clinic may not be able to deal with. In addition it has to perform other basic functions similar to the ones carried out at health centres.

D. Mobile Clinics

These would serve the remote, isolated and most difficult areas of the Riverine States that have intricate system of inland waterways, lagoons, creeks, swamps and islands which hamper efficient medical services. Health services have to be provided for people in these remote and difficult islands through i) Floating Hospitals and ii) Floating Doctor Service.

The floating hospital should have adequate provisions of operating theatre, emergency ward with shower and WC, X-ray room, dispensary and laboratory, laundry room, doctor's consulting room and so on.

The Hospital units of the boat should be adequately equipped to cope with some surgical and obstetric emergencies, conduct routine radiological and pathological investigations and provide outpatient and inpatient care. The floating hospital is seen as integral part of the National health service and designed to serve in bridging the gap between the urban areas with modern hospitals and the rural and the underserved areas with no basic health facilities.

Criticisms: The floating Doctor Service, for example, in the Rivers State, has been criticised (Nigeria Today, 1976) for failing to carry out their responsibilities efficiently and also that they failed to provide continuity of service.

E. Finances

At the inception of the Basic Health Services Scheme, finance was thought not to be a constraint, but optimism and consideration was shortlived (4th National Development Plan, 1981-85, Nigeria). The Federal government

... were deployed to various States of
would provide 70 per cent; the State government would provide something
in the most important areas, for
in the region of 25-30 per cent. The local government was expected to
provide a nominal fund also. The State government is mainly responsible
for the provision of annual revenue allocation for the running of the basic
health unit in connection with training, staffing, supplies and
administration.

1.4.1 Some progress that has been made in NBHSS

Between 1976 and 1980, the Federal government allocated a total sum of N
110 million (£88 million) to the NBHSS and this amount was used to
accomplish the following PHC programmes:

- 12 Comprehensive health centres
- 33 Primary health centres
- 367 Health Clinics

23 Schools of health technology. Each of these has to
perform some of the functions already stated above. Many PHC
programmes at various stages of completion include:

- 22 Comprehensive health centres
- 89 Primary health centres

516 Health clinics. Altogether 264 basic health centres
and clinics have been fully equipped by the Federal Ministry of Health. In
addition, many Primary health workers have been trained to produce:

- 1178 Community Health Aids
- 1268 Community Health Assistants
- 97 Community Health Officers

Several Traditional Birth Attendants.

These trained Primary health workers were deployed to various States of Nigeria to carry out some PHC activities in the most important areas, for example, improvement of immunization schemes and search for solving problems of cold storage and transportation of vaccines; development of 'Health Stable Measles Vaccine' that could survive in the tropical weather conditions, tackling problems of adverse effects of malaria and schistomiasis; tackling occupational health problems in many growing industries; reduction of deaths per vehicle mile and death per automobile; general improvement of health status of the country's population as a whole; dealing with environmental health problems.

Experience has shown that clinical services in hospitals and clinics, while very necessary, have not made very much impact on the amount of sickness and very high infant mortality rates that exist among the rural populations of Nigeria. Therefore, PHC is vitally important with special emphasis on prevention. Problem: Although the Third National Development Plan predicted of increasing basic health coverage of the population from 25 per cent to 40 per cent (Ogunlesi, 1977) most expenditure continues to be on large hospitals particularly the twelve new teaching hospitals which are being constructed, and on expensive technology that has no relation to the fundamental health problems of Nigerians. Again, it has been claimed that external elements also play some influential role in the choice of a modern technological approach to health care provision: An American Department of Commerce stressed that there are opportunities for selling advanced technology such as nuclear medical technology in Nigeria, and notes that the installation of such equipment in teaching hospitals is indispensable for follow-up sales to other health care establishments (USA, Department of Commerce, 1976).

1.4.2 The Fourth National Development Plan 1981-85

Health Programmes and Projects: In 'President Shagari's Fourth National Development Plan', the health sector was considered favourably.

- i) Federal Government: The estimated total capital expenditure for federal programmes in the health sector during the plan period was ₦1.2 billion (£960 million). Of this amount, the National Basic Health Scheme had a financial allocation of ₦100 million (£80 million). The establishment of hospitals, for example, National Hospital for Children in six states had ₦150 million (£120 million). Federal medical centres (teaching hospitals) in seven states had ₦200 million (£160 million). The special hospitals, for example, Orthopaedic, Neuropsychiatric and Dental Hospitals were also accorded priority. ₦26 million was allocated to health training programmes all over the country. Under the communicable diseases, provisions were made for the control of malaria and cerebro-spinal meningitis. Provisions were also made for external work and other infrastructures connected with health care services, for example, building of staff quarters, complete modernisation of decaying health institutions and also every teaching hospital has to establish a centre for Community Health Services at a cost of ₦1.5 million.
- ii) State Governments: States health programmes were formulated largely within the framework of the National Health Service policy and guidelines. As a result state governments also placed

more emphasis on the execution of the national health services scheme, including, building of comprehensive health centres and primary health centres and provision of supporting services such as training of midwives, nurses and other para-medical staff as well as manufacture, procurement and storage of essential drugs. Hospital institutions - general and specialist hospitals should provide referral facilities for treatment or cases referred to them from the basic health units.

Problem: Full implementation and evaluation of each of the above programmes was very much hampered by lack of funds both at national and state levels which consequently left the whole planned programmes overambitious, especially those of: ₦100 million (£80 million) NBHSS; ₦150m (£120 million) National Hospital for Children in six States; ₦200 million (£160 million) Federal Medical Centres in seven States; ₦13.5 million (£10.8 million) Community Health Centres in nine States; Priority allocations to specialist hospitals - the Orthopaedics, Neuro-psychiatric and Dental Hospitals.

- iii) Ministries of Health would ensure the subdivision of the Country into different types and sizes of communities in which NBSS would be organised, taking account of administrative boundaries to facilitate intersectoral collaboration, with consideration being given to these Nigerian communities to organise themselves and to correct delegation to them of responsibility, authority and appropriate budgets. The Ministries of Health would provide guidelines and practical support as necessary to those communities organising their own primary health care.

C. PHC GENERAL MANAGEMENT ACTIVITIES IN NIGERIA

1.1 LIST OF PHC GENERAL MANAGEMENT ACTIVITIES IN NIGERIA

The management of primary health care activities in Nigeria may be grouped under the following headings:

Community initiation and participation in administration and management

Materials and facilities.

Equipment and Transport Materials

Finance.

Personnel and Human Resources.

Patient Services.

Alternative forms of Care.

Communication and Health Education.

Primary Health Worker in Nigeria

1.2 COMMUNITY INITIATION AND PARTICIPATION IN MANAGEMENT

It is claimed that previous attempts to bring about an effective health and community development programmes in Nigeria have often failed because of lack of involvement of the community; and also that the community development workers came from outside and paid from outside rather than in the rural communities. The collective ability of the villagers was totally ignored and not mobilized for the people to decide, act, pay for and

supervise local health programmes in their communities. WHO/UNICEF study (1975) and UNICEF/ WHO study (1977) showed how a number of countries achieved effective primary health care programmes - that they all started from where people lived and that there was active participation of community selected primary health workers as well as community members themselves.

1.3 ORGANISATION OF SERVICES ON A COMMUNITY BASIS

A number of Nigerian rural communities have had well organised rural villages in which the people initiated, promoted and participated in the running of basic health services available to them. The village of Aro; Ikire village in Oshun Local Government Area Oyo; Ikire Health Centre and Immunization Scheme; the Integrated Maternal Child and Family Planning project in a Calabar village; the Ogoja Area Health Project; the Igbo-Ora Basic Health Scheme., the Malumfashi primary health project; the Katsina basic health services; the Shomolu County Health Services in basic health; the Sokoto Maternal Child Work; the Garkida basic health care in Gongola; the Primary Health Care Education project in Kano etc. are examples where community efforts have been mobilised to initiate and run primary health care activities, although some of these are still patchy basic health programmes while others are experimental basic health schemes. However, they all constituted a very small beginning in the field of primary health care delivery in Nigeria.

Amongst these village basic health programmes, it is observed that some of them have had well organised services in their villages as can be illustrated with the following three examples: (please see Appendix 3).

1.4 MATERIALS AND FACILITIES: DRUGS, MEDICAL SUPPLIES ETC.

The major tasks for Nigerian health services managers and supplies officers have been to ensure that material supplies and procurements are adequate and transport services made available and effectively managed in the operations of the overall delivery of Nigerian health services at Federal, State and local government respectively. Appropriate and efficient supplies division at each level plays a significant role in basic health care delivery.

The supplies management functions in the Nigerian health service are wide ranging and the main objectives have been for all the supplies division to become more efficient and co-ordinate some activities to avoid duplication of services, wastage of resources, stoppages, industrial disputes, interruptions etc.

The supplies division of the Federal Ministry of Health undertakes some national supplies management functions and has an executive responsibilities for contracts. The Division's role has been consistent with the need of ensuring that government policy is followed and that efficient and economical use of resources is achieved. The Supplies Division of the Federal Ministry of Health carries supplies management functions which include the following:

1. General policy and guidance to State Ministries of Health, for example, government procurement policy, including conditions for

public service contracts, questions relating to international and Nigerian standards, liaison with other health-related ministries: education, agriculture etc. and other government departments.

2. Equipment research and evaluation policy including financial approval and follow-up: the actual project follow-up work is sometimes undertaken by officers of the Federal Ministry of Health Supplies Division.
3. Other instructions and guidance from time to time to State ministries of Health, for example, variety reduction and authorisation of equipment list for major capital schemes.
4. Review all contract arrangements to determine, with the State Ministries of Health, the level at which contracts should be let.
5. Build up and make available to State Ministries of Health information on all supplies and equipment used in the health service.
6. Where appropriate, make contracts for supplies and equipment on a national or inter-state basis, for example, "The Nigerian Expanded Programme on Immunization".
7. Arrange for government health-related departments' contracts to be extended to State Ministries of Health where appropriate.
8. Communicate full details of contracts to the appropriate State Ministry of Health and co-ordinate consumer reaction.
9. Keep contracts under review with the aim of improving procurement arrangements.
10. Provide highly specialised supplies services (mainly for curative services or research) such as the purchase of complex X-ray and electro-medical equipment and advise on its selection, installation, maintenance and repair.



11. Take necessary action on any other matters referred to the Division by the State Ministry of Health or any other department, for example, on evaluation of equipment.

The state Ministries of Health also perform some supplies management functions which include:

1. Procurement of supplies and equipment which can more appropriately be undertaken on a State Ministry of Health basis (or jointly).
2. Purchasing of goods required, other than specialised equipment, X-ray or other groups of equipment as may be specified.
3. Estimating requirements.
4. Receipt, storage where necessary and distribution of supplies with the State.
5. State co-ordination of maintenance, repair and replacement of equipment.
6. Assessment of consumer reaction for the State Ministry of Health and for the Federal Ministry of Health Supplies Division's use.
7. The preparation of supplies and equipment lists required for capital schemes.
8. General oversight of all supplies matters in the state.

The Local Government or District supplies management functions for the running of rural hospitals, health centres, clinics, maternity homes etc reflect the degree of delegation made by the State Ministries of Health, which is always determined by every State Ministry of Health independently. It is therefore not possible to generalise or be explicit

about supplies functions at this level, having regard to the widely varying sizes and structures of local government areas and State Ministries of Health policies. In some states, for example, Kano and Bendel - Health Boards carry out supplies management functions as well as local purchasing arrangements. However, the main task at every level of government has been to act responsibly and set a good example to staff members regarding drugs: prevent drug wastage; adopt a standard drug-list for a health unit; use a decision-procedure to make a choice between alternative drugs; on the basis of current use of drugs, estimate drug quantities required; order and stock drugs; issue drugs; establish a method to prevent life-saving drugs from being out of stock etc.

DRUGS

Many Nigerian health managers and supplies officers tend to advocate that adequate supplies of drugs must be made available to improve quality of life for every member of the society. It has therefore been the duty of these managers and officers in practical terms:

1. To order the drugs so that the supply falls within the law and is consistent with demand and is timed to allow a continuous supply and is controlled by record keeping.
2. To ensure that drugs are stored to prevent misappropriation and in adherence to proper storage standards.
3. To ensure that drugs are dispensed only under appropriate authority for each category and detailed records are kept.
4. To determine drug needs so that local demand is satisfied.

5. To order supplementary drugs according to the supplementary procurement system, for example, paying more attention to ordering from the 200 Essential Drugs Recommended for use in the Developing Countries by the WHO's Appropriate Health Technology Publications (19..)

DRUG PRODUCTION: An adequate supply of drugs is an important aspect of the health care delivery of a nation. There is yet no one country that produces all the drugs it needs. But it is observed that in Nigeria 85 percent of the drugs needed are imported from abroad and some of these drugs are undesirable because they are proven to be sold to Nigerians after their expiry dates, or alternatively have been banned for human consumption in the countries they are manufactured. What is being demanded in Nigeria is a simple means of manufacturing simple drugs which are effective for basic health care and can easily be manufactured locally at very low costs.

GUIDELINES: The guidelines prepared by the Food and Drugs Administration of the Federal Ministry of Health are designed to help all the indigenous and (overseas) drug manufacturers. Proper labelling of finished products is highly recommended and this must show:

1. The name of the product (proprietary and generic name, if applicable)
2. A qualitative listing of the ingredients.
3. The conditions, purposes or uses for which the drug is intended.
4. An accurate statement of the dosage strength (per tablet, capsule, teaspoon etc).

5. Daily dose.
6. Frequency of administration.
7. Route or method of administration.
8. Precaution for use (shaking, dilution, refrigeration etc).
9. The quality of contents in metric units where applicable.
10. Adequate warnings, where necessary, for the protection of users
e.g. keep out of reach of children etc.
11. Name and address of manufacturer.
12. Date of manufacture, date of expiration and batch or lot number.
13. The labelling must not contain any statement which is false,
misleading or exaggerated.
14. All of the labelling information must be written in English first
and then followed where necessary with for example, Ibo, Yoruba,
Hausa etc as required.
15. Serious disease conditions which cannot be diagnosed or
successfully treated should not be referred to.
16. The advertisement for any given drug should contain:
 - i) the name of the product
 - ii) the pack sizes being promoted and their corresponding
prices
 - iii) the different forms in which the drug is available if
necessary
 - iv) name and address of seller, etc.

There are many reasons why indigenous drug manufacturers are being encouraged in the country as a whole. It would benefit the governments health managers and individual citizens in different respects, for example:

1. Availability of the indigenous manufacturer to account for any defects found during the production process or in the finished medicines may be possible.
2. Creation of work for Nigerians as well as training them in various aspects of pharmaceutical manufacturing and quality control skills.
3. It is not advisable to over-rely or to be too dependent upon overseas manufacturers, especially as they have limited knowledge about Nigerian culture and socio-economic conditions, as well as disease patterns in several Nigerian rural areas.
4. There are bureaucratic problems involved in processing orders coming from abroad and it takes months or even years in some cases to obtain some drugs. This may not happen with indigenous drug manufacturers.
5. Drug manufacturing locally should make use of local raw materials and additives that have been proved useful through scientific research done in Nigeria by Nigerians.

Drug supply, control or distribution should be properly managed and remain most responsible functions of health workers and supplies officers as drugs are powerful and must be used with skill, knowledge and accuracy, otherwise they are dangerous. Wasting or misusing drugs may cause a shortage of supply, with the result that some patients cannot be treated properly as the case in many Nigerian health institutions today.

QUALITY CONTROL: In Nigeria, control of quality of drugs seems to be confused with analysis of finished product sometimes. The quality of medicine is built into a product and controlled at every stage from the raw material to the finished product. Nigerian health authorities have the responsibilities to supervise, control, impose sanctions on defaulters, in line with government policies on quality control of drugs.

There must be genuine efforts by both the government and individuals to achieve an honest drug quality control through effective national legislation and by-laws provisions at district levels.

The Nigerian Training Hospitals overseas Representatives (UK 1983) observed that the majority of Nigerian teaching hospitals and specialist hospitals lack adequate material resources of medical equipment, transport facilities and above all modern diagnostic equipment such as:

1. Equipment and materials for the treatment of viral diseases
2. Gamma cameras
3. Pressure transducers
4. EMG machines
5. Euro dynamic
6. ERC machines and their components
7. Echo cardiogram
8. Ultrasound
9. Stereo ophthalmoscope

10. CT scan
11. Modern chemic equipment
12. X-ray equipment etc.

However, the (NTH) also stressed that a few teaching hospitals and specialist hospitals in the country are equipped well, run well and helping to advance modern medical science and technology in several respects, for example, there is now an increasing effort to advance technology in medicine as the following aspects are now possible:

1. Heart pacemaker is used to combat chronic heart-blockage
2. Investigation and treatment of urinary incontinence can be treated by use of modern small radio receiver which is totally implanted in the body and which is inductively coupled to an extended battery-operated transmitters worn by the patient
3. Burn wound healing: The treatment of badly burned patients has been drastically improved over the last years by the use of a raised environmental temperature. This has the effect of reducing the energy demands on body metabolism as sensible heat loss from the body surface is reduced.
4. Ultrasonics is clinical diagnosis: Ultra sound is the transmission of very high frequency mechanical vibrations through a medium. The reflection of part of the energy of th ultra sonic wave at a discontinuity within the medium can be used as a means of locating the discontinuing. Location is performed by noting the

direction of a transmitted ultrasonic pulse and measuring the time taken for the reflected echo to return to a receiver.

5. Radiation versus cancer: Radio therapy, surgery and drugs are all used in the treatment of cancer. Radiotherapy uses x-rays, gamma-rays, and other radiations to penetrate deeply into the tissues.
6. Technology in Dentistry: Many tooth restorative materials have become available in recent years and these consist of ceramic particles of assorted shapes and sizes in a matrix of organic resin. Mechanical and physical tests are being made frequently on these composites.
7. Neurological Sciences: The main applications of physics in neurological sciences may include:
 - i) Diagnostic radioisotope investigations (Brain scintiscanning, brain scintiphography, isotope cisternography, isotope ventriculography etc).
 - ii) Measurements of cerebral blood flow.
 - iii) Computing for analysis of cerebral blood flow clearance curves in order to calculate cerebral blood flow values in different brain regions; analysis of E.E.G. and E.M.G. signals etc.
 - iv) Patient monitoring installations for monitoring of respiration pattern and rate and the continuous measurement of intra cranial pressure.

- PRINC
8. Speech: there are now several ways in which sounds can be produced
- i) In the fricates (eg) (s), (f) the source is a 'noise source' consisting of turbulent air flow through tongue and teeth, lips and teeth etc.
 - ii) Plosives (eg) (p), (b), (t) are produced when air is allowed to suddenly escape from a closure (eg) at lips in (p) or between tongue and hard palate in (t).
9. Hearing: Techniques to assess hearing functions have become increasingly sophisticated. Conventional audiometric tests such as speech discrimination assessment and automated pure tone audiometry are refined to determine the degree of hearing loss as well as to indicate the site of disorder. Technologies that relate to health care according to Parker (1978) varies from all the methods, techniques, instruments, equipment, drugs, biological substances to other complex actions taken to achieve certain outcomes. Simple and cheap technology must be developed to meet local health needs and appropriate health technology should evolve from efforts to find simple responses to common health problems in the rural communities. Fedall (1977) stressed that simplified care does not mean ineffective responses, rather it means care that is relevant to the problem presented within the constraints of the situation. Those constraints are, for example, limited resources of finance, skilled manpower and facilities etc.

1.5 EQUIPMENT AND TRANSPORT MATERIALS

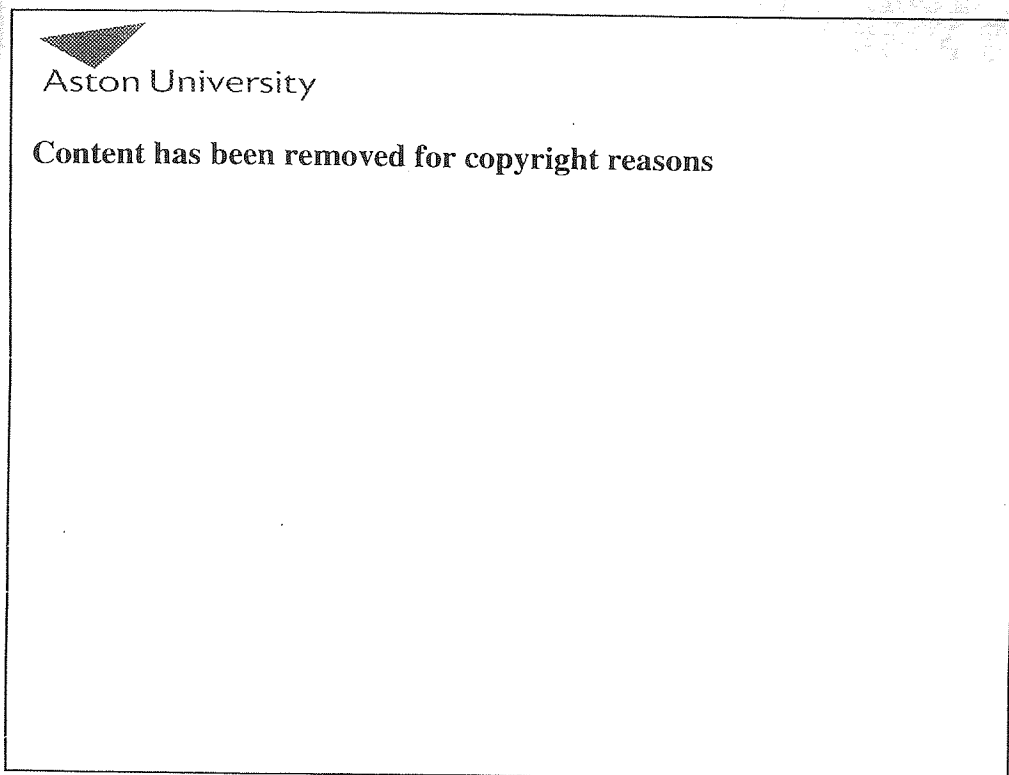
Appropriate technology must be safe, acceptable, feasible and effective. This should apply, not merely to techniques and mechanical devices, but to persons and processes as well: staff, training, equipment, facilities, supplies, information systems, transport facilities and buildings, etc. An effective adaptation of appropriate health technology to rural environment.

- i) requires the knowledge, attitude and information about the community in relation to disease and health conditions
- ii) must be health problem oriented and definitive in diagnostic terms
- iii) quantitative and qualitative analysis of task and facilities needed to perform specific tasks in the community
- v) clear understanding of the cultural, economic, financial constraints.

King et al (1977) subscribed the use of Systems Approach for the simplification of health technology through a method of detailed technological planning or health micro-planning.

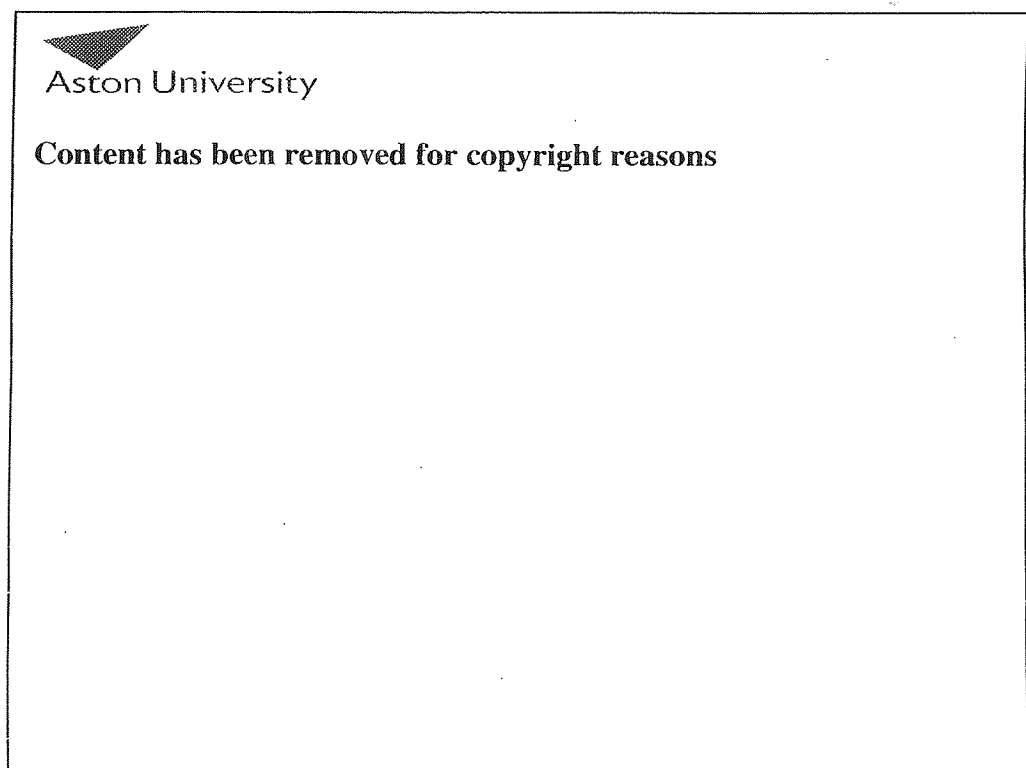
Park (1978) devised what he called the sequence of health technology modification process which is shown below.

FIGURE 2 THE SEQUENCE OF HEALTH TECHNOLOGY SELECTION



SOURCE : Parker, A. Health Technology and Primary Health Care,
Social Sciences and Medicine Vol. 12 p. 32, 34.

FIGURE 3 HEALTH TECHNOLOGY MODIFICATION PROCESS



Bridgman et al (1980) stated that it is too often overlooked that buildings, machines, instruments, mechanical and electrical equipment and textiles are subject to obsolescence and prone to failures. Bridgman's claims have more implication for Nigeria where it is always too difficult to have at hand a team of skilled technicians able to maintain and repair both complex and simple machines and equipment that have been supplied to health centres, clinics, maternity homes etc. for use.

In Nigerian basic health care, appropriate technology would also mean that in primary health care activities, good primary health care managers should be able to take good care of equipment, for example, by:

- i) instructing and motivating personnel to feel responsible for the equipment they use
- ii) ordering supplies when needed
- iii) storing them safely
- iv) controlling their use.

But it is generally observed that these health managers have not gained understanding of recognising the necessity for adequate control measures to be exercised over health authorities assets, equipment, machines etc.

Expendable equipment needs to be controlled to avoid wastage. Non-expendable equipment needs to be maintained i.e. kept in good working condition. To control and maintain equipment, PHC managers should have the necessary skills, for example,

- a) to convince personnel of the importance of cleaning, inspecting and keeping equipment in good order; to report defects immediately; and to replace equipment after use.
- b) to use an inspection check-list and an inspection schedule
- c) to detect discrepancies and explain them.

There is no easy way to convince staff of the need to clean equipment and keep it in good condition. However, the best way is for the supervisor to set a good example and to emphasize that equipment must be cared for:

- 1. to prevent transmission of infection e.g. by a dirty instrument
- 2. to keep it in good condition - dirty or damp equipment deteriorates more rapidly than equipment that is kept clean and dry
- 3. to economize
- 4. to improve overall health service efficiency.

The value and use of equipment records is important hence health managers and supervisors are being encouraged to appreciate the good control measures may be used, for example, to

- i) standardise primary health care performance in order to decrease efficiency and to lower costs: inspections, written procedures etc
- ii) safeguard the assets of health centres, clinics, rural hospitals, maternity homes etc. from theft, wastage or misuse: good record keeping, custody and proper use of assets, develop system of authorisation and record keeping etc.

- iii) standardise quality to meet the specifications of senior PHC managers. Examples here include inspection and statistical quality controls which analyse a sample of work to gauge how far general quality is up to standard.
- iv) to set limits within which delegated authority can be exercised without more senior PHC managers approval, examples, include organisational charts and manuals of procedure, policy directive, internal audit, decentralisation of planning and decision-making from centre to local health authorities and periphery.
- v) measure performance on the job e.g. special reports, statistics of output per member of staff, budgets which set out the amount of resources allocated to, or expected to be used in PHC activities
- vi) plan and programme operations e.g. forecasts, budgets of resources and output etc
- vii) enable senior health officials to keep the PHC managements programmes and plans in balance e.g. general operating plan
- vii) enable senior health officials to keep the PHC managements programmes and plans in balance e.g. general operating plan
- viii) motivate health workers to contribute their best.

APPROPRIATE TECHNOLOGY FOR NIGERIAN BASIC HEALTH SERVICES SCHEME

Technology plays a role daily in several activities of life in the rural communities of Nigeria: in the transport facilities provided, the injection received at health centres and clinics, in the food that is produced and eaten, in the manufacturing local industries, in choosing appropriate, basic and simple drugs. It may also be expressed in terms of comparing the multi-stage submersible pump and the windlass mounted over the village well, or traditional medicine against the latest technology and techniques in modern medicine. Since it embraces different forms and characteristics, technology in the rural communities of Nigeria for use in the village must be nothing less than a means to an end designed to achieve improvement in the quality of life in the villages. It must have a potential of meeting the basic needs of these villagers in the areas of housing, basic health care, employment opportunities, agricultural development and farming methods, roads and infrastructure of these rural communities. It can only do this if appropriate technology is chosen and properly applied to match local environment and requirements. So far this has not been the true picture in several Nigerian villages.

Technology that can meet local requirements in the villages, may also demand certain specific technical know-how or expertise to use it. If a Nigerian charity, for example, donates or raises funds which can be used for sinking of a borehold and the installation of a turbine pump to provide water supply to a rural community with no reasonable water sources, this may lead to an improvement in the quality of life enjoyed by the beneficiaries. But if there are no spare parts and no skilled expertise to

keep the pump running then that rural community may be back where it has been just as soon as the pump breaks down. In such circumstances, the Nigerian charity will have achieved no long term advantage and it would have been better if the funds had been spent to dig wells in several Nigerian villages without water and equip them with hand pumps which do not easily go wrong, and when they do, can be quickly put right again. This would not only have provided a sustained level of improvement but more people in these villages would have benefited from choice of appropriate technology in this direction. Appropriate technology for Nigerian rural communities requires simplicity not sophistication that lends themselves to a high degree of automation, especially as skilled people of the calibre needed for them are just not always available in the villages and in certain situations they are totally unavailable. Appropriate and simple basic technology required must be cheap, reliable, consistent in meeting the basic human needs in the rural communities. It also means being careful to choose what to buy as that view that what is bought from the market must be the 'latest thing' may be challenged if it cannot match the community expectations or needs. It can be hypothesised that appropriate technology for basic health care in Nigeria may be based upon different cultural-tribes of the country - Ibo, Yoruba, Hausa etc which may be more acceptable to members of these groups and, in turn, make primary health care more acceptable to them and to Nigeria in general. But the current technology available to Nigerian basic health care has not been developed, used or chosen in accordance with local disease patterns which:

- i) address particularly the health problems that need to be tackled
- ii) is acceptable and compatible with the social and cultural attributes of the rural community that have them

- iii) is available to community on continuing basis: reliable, feasible etc
- iv) is safe and effective
- v) contribute to personal and community development
- vi) is affordable
- vii) is not complicated to use: knowledge, skill, supervision etc.

The delivery of primary health care in Nigeria requires the use of facilities and equipment which are physically and functionally related and can be obtained at a cost that is compatible with individual, family, community and national economic resources.

1.6 FINANCE

The Federal budget allocations to health sector in Nigeria had always been too small in almost every Nigerian National Development Plan when compared with those of other sectors such as education, agriculture etc. The budget allocations to health had also remained inconsistent from one national planning programme to another as illustrated below:

In the 1946-56 National planned programmes, for example, health sector was allocated only 2 percent of the total national budget. In 1962-68 national development plan, health allocation was increased to 2.5 percent of the total national budget and increased to 4.5 percent in the 1970-74 national development plan. But this percentage was drastically reduced to 3.5 percent in the 1975-80 national development plan which again was increased to 5 percent in 1981-85 which due to weak national economy and the global recession in this period, could not be fully implemented.

The Federal health allocations have always been made to meet some of the important health needs of the country and in the recent national development programmes, the immediate health needs included the following.

- i) implementation of measures to improve health facilities and services
- ii) expansion of programmes in primary health care
- iii) expansion of programmes for the maintenance of environmental sanitation
- iv) institution of measures to control communicable diseases
- v) development of manpower through provision of appropriate facilities of training programmes for health workers
- vi) re-organisation of rural hospital services
- vii) creation and development of research facilities
- viii) financing and maintaining health standards throughout the country
- ix) building and equipping comprehensive centres, health centres, clinics, maternity homes etc
- x) building and equipping teaching hospitals.

But in several respects, the inadequate budgets federally allocated to health sector have never been able to achieve the objectives which they were designed to achieve. The reasons for this may be stated as follows:

- i) it has been observed that finance officers, health planners and decision-makers in the Nigerian health service lack knowledge of

the real health needs of the country and more disappointingly knowledge about the basic health needs of the rural communities

- ii) Health resource allocation within the health sector itself is not effectively based on equitable distribution, which gives priority to the deprived areas and rural communities and the peripheries.
- iii) the low income group, the poor, children, the aged etc have not been adequately considered as special groups needing greater health care provisions
- vi) the big city hospitals still absorb over 80 percent of health resources available, leaving the rural communities with little or inadequate resources to provide the basic health care
- v) many Nigerian health planners tend to copy Western model in health planning, which does not consider cultural constraints, socio-economic situation, political realities in Nigeria
- vi) politics and health service are complementary to each other in Nigerian, and it is not always surprising, that in certain circumstances, politicians who really know little and who care less about people's health may be appointed health ministers
- viii) other reasons include social divisions and sectional interests which afflict the 100 million Nigerians; lack of national or political will, lack of good alternatives of financing Nigerian health service via, for example, insurance schemes, etc.

PRIMARY HEALTH CARE FUNDING

The provision of primary health care or health care services at any level of health system depends upon adequate funding to meet staff salaries, drugs, maintenance and other related costs annually. Bridgman et al (1980) stressed that methods of financing health care services are not just question of choice between various systems, but are conditioned by political systems, the economic situation and their cultural acceptability. In Nigeria, no other national methods have evolved for financing health services other than general taxation, and no national methods exist for providing health services, for example, some northern states receive free medical treatment funded by their respective governments, while in all the southern states, patients have to pay for treatment at various points of contact with the health service. Some civil servants and their families receive free medical care which is arranged and funded through their organisations but they may be also reimbursed for all expenses they incur for health treatment according to one's professional status or seniority in his organisation.

When compared with industrial or advanced countries, the Nigerian overall spending on health is generally low. Inadequate funding of health services is felt serious in most of Nigerian rural areas as the bulk of health expenditure is concentrated on curative care in the city hospitals.

It has always been suggested that a combination of national insurance and private insurance, health taxation, general taxation should be carefully considered as alternatives for financing Nigerian health service

adequately. But insurance system cover by Nigerian governments has never been possible and national insurance requires a large proportion of salaried workers while private insurance may be only possible if the population is keenly health conscious and able to pay for it. The most single system of financial health service in Nigeria has remained general taxation while several other options mentioned above have not been considered. For example, a feasibility study (1981) has revealed that local resources may be tapped fully, not just in terms of raising money through taxation, but also making efficient use of available resources in the rural communities to lower health costs, for example; the Traditional Birth Attendants (TBAs) can be retrained as well as the Traditional Healers to influence staffing patterns in primary health care activities, health centres, clinics, maternity homes etc. Furthermore, the village people themselves may be taught how to care for themselves to improve health and this can save government some money as well as resource wastages.

The situation in majority of the Nigerian villages makes the poor to bear the heavy burden of paying more taxes for health care and receive nothing in return health wise. This is being criticised and both Nigerian governments and health management authorities are being asked to provide sufficient funds to finance health services in the whole country, with greater emphasis to adequate funds for basic health care provisions in the rural communities. Equally, funds provided for primary health care must be properly managed, for example, by:

- i) distributing money so that rural health services in the communities receive their allocations in time

- ii) planning the financing of rural health services so that health needs of the villagers are met
- iii) lobbying for correct receipt of the money
- iv) controlling the money so that none is misappropriated: this requires efficient financial management, good control process and expenditures incurred are within budgets
- v) writing necessary reports on district or Village Health Committee's performance and establishing the system for facilitating communication to avoid unnecessary bureaucracy or red tape.
- vi) liaise with money-giving charities, organisations etc. so that money arrives on time
- vii) maintaining mini-budget expenditures within defined total budget
- viii) ensuring maintenance of minimum standards in financial training of staff: financial management etc.

1.7 PERSONNEL AND HUMAN RESOURCES

Many health managers and senior health officials such as heads of departments tend to pay less attention to personnel matters and more to other managerial functions in the Nigerian health service. This lukewarm attitude to personnel services by health managers in Nigeria has led to some militant tendencies and work stoppages among several health workers, for example, the 1980 official strikes by Nigerian junior doctors, who have had pay disputes and other grievances with the management were widely covered by the Nigerian press and radio broadcasting. The Nigerian health managers, have not, in practical terms, recognised that they are fully responsible for their own personnel policies or lack of them: a

personnel policy being that part of the overall policy which expresses the attitude of management to the problems which affect staff.

Although the Nigerian health service is one of the country's largest employers of labour much of it highly skilled: the hospital and health centre services have made little progress toward developing a comprehensive and well integrated personnel function which is extended to cover rural health services also. Four main reasons are held responsible for these trends:

1. The existence of several and separate employing authorities: Governments, missionaries, industrialists, higher educational institutions etc who run their own health care systems.
2. Personnel management, still in a developing stage in the Nigerian health service, has not often been regarded by the members of health professions as a sphere in which they have a major part to play, their essential concern having been seen as providing a service to patients.
3. Up to the present time, the growth of personnel officers has been slow but steady in Nigeria, because of limited resources available.
4. A hesitancy to accept the need for specialists in the personnel field on the basis that departmental heads had hitherto conducted their own personnel responsibilities within the health service.

The personnel management functions in Nigerian health service embraces a number of facets. It is concerned with recruiting and selecting staff; training and developing them; ensuring that their payment and conditions of employment are proper, where necessary negotiating such terms of employment with trade unions; advising on health and safety regulations; organisation of people at work and encouragement of the most appropriate climate of relations between management and staff. These personnel functions may be grouped under the following heading:

1. Employment
2. Salaries and wages
3. Industrial relations
4. Health and safety
5. Welfare.

EMPLOYMENT: The Manpower Services Division of the Federal Ministry of Health perform some personnel activities of which a large number of these activities are concerned with management and deployment of staff, to ensure that staff are able to use their skills most effectively. These personnel activities include all aspects of manpower information and planning, recruitment, promotion and appointments arrangements, training and career development with associated staff appraisal and counselling, the negotiation and interpretation of pay and other conditions of service, arrangements for consultation with staff interests and for the welfare of staff: these also include those activities that arise from working situations, consultation, organisation and grievance and disciplinary procedures. However, it is widely believed that inadequate employment policies in the Nigerian health service affect health workers and prevent an efficient use of available manpower resources.

What is required has been an employment policy or policies which give health workers opportunities to develop their potential through careful and proper mix of selection and recruitment methods which can be determined through certain activities, for example:

- i) deciding qualifications and experience required
- ii) consider filling vacancies by internal transfer or promotion
- iii) base selection on suitability for the job
- iv) explain fully terms and conditions of service
- v) check methods to ensure they are effective
- vi) ensure that those responsible for recruitment and selection are competent
- vii) establish and monitor both job specification and job description (the former is a definition of physical and mental activities involved in a job and if appropriate, the social and physical environmental matters, that is, what the job holder does, what knowledge or expertise he uses in doing it, what judgement he makes etc., while the latter means a statement of the purpose, scope, duties, responsibilities and relationships of a particular job etc. Job analysis is also vital, being itself a process of examining a job to identify its component parts and the circumstances in which it is performed.

MANAGEMENT DEVELOPMENT, TRAINING AND EDUCATION

The Nigerian health authorities and managers have been involved in different management training and management development programmes for health workers through, for example,

- 1) assessment through confidential staff reporting
- 2) planned movement of staff
- 3) taking of professional qualifications
- 4) formal training including courses
- 5) advancement by means of appointment procedures.

But lack of adequate training and management development programmes have left the service inefficient. The official assessment of manpower requirements and efficiency has been erroneously based on:

- i) statistics of cost figure
- ii) the negative evidence of lack of complaints
- iii) the subjective element of odd personal contacts with senior health officers
- iv) incompetent supervision

TRAINING OF HEALTH WORKERS

1. **DOCTORS.** The Nigerian doctors play an important role, not merely as the most highly qualified providers of health care at secondary and tertiary levels (in district, general and specialised or central hospitals), but perhaps regrettably not as educators of primary health workers. There is need still for Nigerian doctors to be educated in their relationships with the primary health workers, particularly the village health workers, which have tended to be one-way relationships. Emphasis for medical training has not been put on active involvement of doctors in basic health care provisions and to move away from curative high-technology medicine in the

big city hospitals which have proved ineffective for solving health problems of the mass Nigerians. As well as a reorientation there is real need for a redistribution of doctors to rural areas and districts and the peripheries. This would not only make health care available to all but may also increase the levels of utilisation of services in these rural villages.

The Nigerian National Health Planning Document (1975) stipulated that the role of Nigerian doctors would be changed drastically so as to become consultants, teachers and leaders of health teams. Following this suggestion, arrangements were made for some crash training programme for community health officers and assistants, after which they would take on more clinical functions in the rural communities. This kind of training programme was mainly scheduled for nurses which the Nigerian Medical Association did not favour but opposed it on the grounds that such clinical functions have always been performed by nurses in both general and rural hospitals. But the real interpretation given to the Nigerian Medical Association's opposition, has been that there is no need for training what the doctors called 'mini-doctors': the medical assistants, officers, medical auxiliaries to provide health care on a large scale as this would lower standard of medical care. The Nigerian Medical Association (NMA) tend to share the views of Beckett (1975) and Smith (1978) that from an onset, there should be a clear career structure rather than introduce auxiliaries as a step towards obtaining full medical training which does not match up with medical care, expectations and professional ethics.

The (NMA) would rather prefer that the training of primary health workers aim at producing multi-purpose personnel to reduce the need for specialists who are also hard to recruit, a point that seems to be supported by Abel-

Smith (1976) when he stressed that elaborate staffing and equipment than is really needed in health centres should be challenged and resisted.

2. **OTHER HEALTH PERSONNEL:** Majority of specialised paramedical health workers in Nigeria: the physiotherapists, radiographers, laboratory technologists, dental surgeons, pharmaceutical chemists, medical records officers etc. have not adequately been reoriented towards elementary training needs in basic health care. Concretely this means having an increase in the teaching responsibilities of these paramedics so that either specific new primary health workers which must include auxiliary laboratory technicians, multi-purpose auxiliaries etc would learn to perform the basic techniques of certain specialised skills of these specialised para-medics, with increasing emphasis on adaptation of these skills to community health needs and provision of rural health services. This would also require a major geographical redistribution of these skilled auxiliary personnel to function as part of primary health care teams in various local communities of the country.

The recent assessment of health manpower levels in Nigeria for different categories of health workers has been discussed under Health Administration in Nigeria (Please see Appendix 2).

3. **SALARIES AND WAGES:** An independent body or Udoji Commission as it is called was appointed by the Federal Government in 1979 to look into wages and salaries structures of several Nigerian civil servants, including health workers, which have been too low and to recommend offers of improvement in salaries, wages and conditions of work. The Commission recommended increments in line with the national

economy/inflation, the position held at work, specialist work done, experience that have been acquired etc. and the recommended salaries and wages cover the period up to retiring age which in Nigeria is 60 for men. This independent body also provided for contract appointments within the health service for specific periods of time in which staff member if eligible for the same contract gets 'contract addition' equivalent to 25 percent of basic salary.

The Commission also recommended some improvements in benefits for the civil servants such as car allowance, provision of part-furnished accommodation if available for staff grade levels (GL) 10 or salary scale N 5,460, N 6,432 and above:

GL 16 N 11,268 - N 12,426 being the top scale for senior officers and chief executives, directors of Administration and permanent secretaries.

Holiday payments include annual leave and travel allowances. Similarly the salaries and wages of different groups of workers in the health service: medical, dental, administrative/clerical, nursing, optical, pharmaceutical etc are all offered improved salaries and wages with beneficial terms and conditions of work according to one's own standing in the service.

The primary health teams though paid by their state governments have not been given a uniform system of pay structure achieved for them in line with Udoji Commission or similar independent body that has been appointed by the government. Inevitably, this gives the primary health workers some disadvantages especially in the rural communities where their salaries and wages are so low that health workers are not attracted to jobs there and it

also makes recruitment of the new people (the villagers) into the service difficult. In some states, some local communities cannot even afford to provide accommodation for the primary health workers and their teams and the conditions of work are generally bad.

However, it is generally observed that payment systems in the Nigerian health service vary according to the States' different requirements and available financial resources to meet or pay higher salaries and wages but in general, every health authority of state governments try to ensure that:

1. payment systems have been kept as simple as possible, consistent with their purpose, so that employees can understand them
2. based on some form of work measurement where possible and where payment is linked to performance (e.g. laundry etc)
3. jointly negotiated where trade unions are recognised
4. based on Udoji Commission recommendations.

Differences in remuneration have been related to the requirements of a job, which if necessary, are assessed in a rational and systematic way in consultation with employee representatives to ensure that they suit current labour changes and changes in the organisation of work requirements, for example, some form of job evaluation has become invariably part of a salary and wage policy in Nigerian health service of which the primary aim is to achieve equitable internal pay relationships. That means a process of determining systematically and as objectively as possible the differential rates of relative job worth and these relative requirements of jobs are mainly determined in relation to skill, experience, working conditions and general responsibility, especially for the grade level workers of 'GL 5 - 10; GL 11 - 13 and GL 14 - 16' respectively.

It is with this process of assessment of relative job worth in Nigeria that logic, justice and equity are achieved or maintained.

SAFETY AND HEALTH

Safety and health requirements are part of a personnel policy and these are of some concern in the Nigeria health service for three main reasons:

1. Humanitarian; on the basis that if management obtain and use the services of staff, there rests a responsibility to ensure their health and well-being. There is, therefore, the need for a good employer to do something extra beyond what he is obliged to do by law or by nationally negotiated agreements. In the hospital or health centre services, this may enable an authority to compete on equal terms, to secure and retain staff.
2. Financial; the amount of time lost through sickness and absence from work expressed in financial terms, is staggering and greater than that lost through disputes.
3. Legal; there is greater need to provide minimum health safety standards by statutory requirements for health workers. Occupational Health and Safety Officers are being trained in order to help reduce or eliminate health hazards in health institutions: noise, fatigue, fire, etc. as well as instructing in safe working methods, supervising the continued use of such methods; initiating any steps necessary to improve the safety conditions.

In addition the occupational health and safety officers have been trained to have major supervisory role in many Nigerian hospitals, health centres etc and this supervisory role ensures that they:

1. use the safety devices and equipment provided as legally required
2. report any conditions they think may be dangerous
3. suggest ways in which the work could be made safer
4. help in training of new entrants and young persons particularly by setting a good example of safe practices.

WELFARE

There is a relationship between health and safety and welfare of staff which justifies linking these as one function of the personnel units, divisions or departments within the Nigerian health service. There are essentially two types of welfare services which the Nigerian health workers have always been concerned about namely:

- a. Physical environment: lighting, ventilation, noise, good housekeeping, fatigue, working hours, shift arrangements etc. for example, bad working conditions can cause strain and breed problems; efforts to motivate can be vetoed by discord; results of bad conditions can include irritability, strain, fatigue, sleepiness and deafness.

If working hours and breaks are properly adjusted, output level can be maintained and fatigue can be eliminated or reduced.

Similarly if working hours and shift arrangements are carefully worked out, there could be improvements in output, morale and recruitment.

b. Benefits and services: The principles to guide the provision of these services by management have to show that:

- i) management does not obtrude into the private lives of health employees through welfare schemes;
- ii) amenities should be provided only when desired by employees
- iii) the amenities provided should be beneficial in the long run to both management and employees.
- iv) the benefits and services provided include:
 - 1 financial protection against risks e.g. illness, accidents, retirement, removal, education etc
 - 2. meeting the social and recreational needs of employees
 - 3. aids to recruitment and retention.

However, as employees' outlook is largely - often wholly - shaped by experience of their own department, main need is for good departmental management generally, which entails:

- 1. capable departmental head in terms of technical proficiency; managerial ability, adequate attention to the needs of his staff. When perhaps occasional unwise appointment of departmental head who does not consider employees' needs, welfare and

benefits, staff may be resolute in remedying it, for example, either by arranging training, demotion, transfer or ultimately by replacement of their boss. Equally, administrators must give all possible help and support to each department in:

- i. management and office matters in which he is expert
- ii checking for overloading of department and taking necessary action
- iii efficient co-ordination of work of all departments
- iv scrupulous attention to communications, staff interests and welfare of employees.

In general therefore, the management must follow whole-heartedly the recognised policies of welfare of staff; individually and collectively to help provide the right climate for efficiency of work. Appropriate welfare policy is always desirable to staff and this must be directed to providing certain services also, for example:

- 1. subsidised meals
- 2. good changing accommodation
- 3. issuing protective clothing and uniforms
- 4. assistance with examinations and tuition fees etc
- 5. provision of transport and reduced fare, especially in the rural areas or where early starts or late finishes are involved
- 6. provision of creche facilities
- 7. paid leave for authorised absences other than sick or annual leave
- 8. insurance schemes
- 9. provision of loan facilities

10. counselling services
11. sports and social clubs with social, recreational and sporting activities
12. circulation of a magazine or journal
13. appropriate staff handbook etc.

1.8 PATIENT SERVICES

1. AVAILABILITY AND ACCESSIBILITY OF HEALTH SERVICES

Availability and accessibility of basic health care to everybody, especially to the village people, are the fundamental requirements of an effective primary health care in the rural areas of Nigeria. Maurice King (1961) suggests a number of principles on which primary health care should be based, stressing that:

1. Patients should be treated as close to their homes as possible in the smallest, cheapest, most humbly staffed, and most simply equipped unit that is capable of looking after them adequately.
2. Some form of medical care should be supplied to all people all the time.
3. In respect of most of the common conditions there is little relationship between the cost and size of a medical unit and its therapeutic efficiency.
4. Medical care can be effective without being comprehensive
5. Medical services should be organized from the bottom-up and not from the top-down.
6. The health needs of a community must be related to their wants.

It is suggested that if King's principles are adapted to Nigerian rural health services in particular, primary health care would be available and accessible to the village people, although it must be stressed also that other factors such as costs and relevance of services being provided also determine both accessibility and acceptability in several Nigerian communities. This point can be illustrated, for example in the northern part of Nigeria, financial barriers do not constitute any personal problems since almost all the northern states provide free health services for their people but this has not increased people's access to basic health care. One theory suggests that this may be partly due to Hausa cultural and Islamic beliefs about causes of illness (as discussed in chapter four) and partly due to ignorance as almost 97 percent of Hausa people are illiterate.

In contrast, most of the people in the southern Nigeria are becoming very aware of need to seek health care in hospitals, health centres, clinics etc but not without problems. Some of these problems are associated with the increasing costs of health care which tend to scare patients and which reduce the level of accessibility. The reason for this is of course that there is nothing like free health services. Many government general hospitals are known to overcharge patients and they also retain bureaucratic (red-tape) methods of seeing patients. Unlike the Hausa people in the north, the southerners are more educated and this may explain the eagerness on their part to seek modern health care but equally, they like the Hausas, have some cultural beliefs which may prevent people seeking modern health care, especially for certain illnesses, which are believed to be chronically useless to seek any cure (e.g. leprosy), or illnesses that are spirit-caused (e.g. illnesses associated with witchcraft).

In both north and south however, there are other non-financial barriers that exist which reduce people's access to basic health care, for example, the inadequate provision of permanent health care facilities force some patients to patronize alternate sources of care: private physicians, pharmacies, chemists, traditional care etc or simply that a patient has to pay a bribe at government hospitals in order to get valued treatment as has been described by Igun (1979). There maybe other problems involving indirect costs and opportunity costs forgone in the process of seeking modern health care and these on aggregate reduce the level of both availability and accessibility of health care to the majority of Nigerians. Even at health-institutional level, the village people have negative images of hospitals and health centres as Stock (1981) has stressed: a long waiting time to obtain treatment may be experienced, these health institutions may be overcrowded most of the time causing some confusion, hours of operation may be irregular, diagnosis may not be carried out in private, cultural beliefs and local traditions may not be taken into account when a patient is diagnosed etc.

These health-institutional barriers are unpleasant to patients and may cause a patient to delay or refuse to seek treatment as they tend to develop into psychological barriers as well, which often clash with the health-institutional barriers. McKinley (1972) pointed out that bureaucratic organisation of health care services for the poor, the lack of skills in dealing with bureaucracy among the poor, and the lack of understanding by the health care establishment of basic tenets of the working class subculture constitute barriers to effective utilisation which are reflected in low levels of health care utilisation by the poor. Unlike in

the developed countries where utilization of health care increases with age but relationship is non-linear according to Andersen (1968), in Nigeria and most of other developing countries, proportional use of Western medicine decreases with age, while proportional use of traditional medicine increases with age (Nchinda 1975); (Maclean; Nigeria, 1966); (Ademuwagan, Nigeria 1977). Equally, Aedbiyi (1977) concluded that under 10 percent of the outpatients of Ife-Ijesa dispensaries in Nigeria are over 18 years of age. Illiteracy also constitutes danger to health. Ademuwagan (1976) found that in the South West of Nigeria, education positively related to choice of hospital cure and chemists, but negatively related to use of traditional medicine. Moran (1973) discovered that vaccination acceptance in Nigeria positively related to years at school while Uyanga (1979) claimed that 68 percent of traditional doctors' patients in Nigeria are illiterate, while 62 percent of patients of spiritual healing churches had completed primary school education. Maclean (1971) stipulated that there is less use of traditional medicine in the Western Nigeria when father and especially mother had attended school. Additional to all these barriers, the gross urban/rural maldistribution of health care services and resources makes basic health care relatively inaccessible to majority of rural communities in Nigeria.

It has long been suggested in Nigeria that access to health care may be better achieved if the distance travelled by patients to seek care is on average reasonable. Jolly and King (1966) found that attendances per capita in Juganda halve every 2 mile for hospitals and dispensaries and every 1 mile for aid posts; the in-patient admissions halve every 3 miles. Jolly and King also showed that out-patient visits in India are halved each $\frac{1}{2}$ mile of distance. Winter (1972) claimed that in Central Malawi, 47 percent

of patients travel under 1 mile; 91 percent of patients halves every 9 kilometers for in-patients and 4 kilometers for out-patients. It was shown by Gish and Walker (1977) that in Botswana out-patient attendance/100/year was 103 at 0-4 miles from clinic, 51 at 5-9 miles and 24 at 10+ miles and for the in-patients 11.9 at 0-4 miles, 4.2 at 5-9 miles and 1.2 at 10+ miles. Many other similar claims have been made in several studies by Schulpen (1975) in Tanzania; Kreysler (1970) in Kenya, and Danfa (1979) in Ghana. On average it would appear, however, that a distance of 5-10 miles is recommendable for patients to travel in order to reach health care facility or gain reasonable access, but other factors must also be taken into account about reasonable distance for a patient to travel locally before reaching the nearest health facility, for example, the population density and disease patterns of the locality etc. In Nigeria however, inaccessibility to basic health care is mainly due to fewer health facilities available which are not near to patients' homes. The efforts of Nigerian governments since the advent of Health for All by the year 2000 (HFA/2000/WHO/UNICEF 1978) have been directed to allocating some resources to the Nigerian Basic Health Services Schemes and to redistribute these health resources equitably especially in the peripheries and villages and also to change the static work in the health centres to become more dynamic, for instance through increasing home visits; urging communities to participate in basic health care efforts and community development programmes. Many other people in Nigeria tend to argue that availability and accessibility of basic health care to everybody can only be achieved if the health suppliers:

1. can lower costs of health care
2. able to motivate the decision-makers to supply adequate resources for adding health facilities, especially in the rural areas
3. adopt good planning methods which must include efficient use of available resources
4. are skilled in forecasting, planning and organising the addition of health posts in the isolated and rural communities
5. are able to communicate with the village people in order to recruit village health promoters, primary health workers etc.
6. have ability to persuade village people to participate in primary health care activities and decision-making process.

Furthermore, access to basic health care may be achieved also if certain conditions are met at individual, community and government(s) levels, for example:

1. adequate income distribution
2. organisation of nutrition and health services for the marginal populations
3. integration of organised community into a process that creates conditions that are beneficial to those with limited resources
4. taking actions to extend health coverage which have a permanent impact on communities and which contribute to infrastructure of information and which support activities to strengthen community development programmes
5. modernization of existing basic health units
6. construction of more basic health units

7. preparation of additional health manpower to work with primary health teams etc, including hundreds of primary health workers.

2. QUALITY AND APPROPRIATENESS OF CARE

Quality of care may, in this sense, refer to the kind of treatment a Nigerian patient receives or likely to receive at health centres, clinics, rural hospitals etc or from a visiting health worker. Quality of care itself is related to the competence of the health professionals and the kind of decisions they make in the process of health care delivery which affect patients directly or indirectly. Quality of care also relates to some careful analysis of treatments given, of rates of use, and of follow-up and monitoring procedures to assure that the patient is given good or appropriate medical care.

SERVICE ORIENTATION: Service orientation here refers to the attitudes of the Nigerian health providers to patients which seeks to find out, for example:

- i) if the patient is treated with respect
- ii) if health care given is appropriate to the particular/cultural ethnic groups: Ibo, Hausa, Yoruba etc.
- iii) if health care given is appropriate to age, etc
- iv) whether patients participate in decision-making which affect their health
- v) whether patients are encouraged to take active preventive measures and to be responsible for the maintenance of their own health

- i) whether efforts are made by the management to ensure that doctor/patient relationship is a satisfactory one
- ii) whether patient's condition is explained in a way he/she understands.

Service orientation may also be extended to cover certain activities, for example;

- i) the need for increased skill of health workers through in-service training
- ii) adequate supply of drugs and equipment
- iii) a good referral system
- iv) regular guidance and supervision of health workers and health activities.

It is widely believed amongst the rural inhabitants in Nigeria that Western medicine creates negative and poor image and that these negative images surround very specific complaints arising out of bad personal experiences of the village people, such as their nebulous, in specific feeling of unease about the health centre, clinic, hospital, and the way or manner treatment is provided in them and service orientation. Rumours and various allegations have been made by several village people about malpractice and these rumours and allegations spread rapidly and attain credibility without difficulty. There is, for example, a deep fear in the minds of these villagers that fractures must not be taken to a health centre or hospital since the injured limb will be amputated by modern health practitioner.

But more than this, other allegations made against modern health care surround the organisation of health care services; the cultural discontinuities; the credibility of Western-type medicine; the quality of care; and corruption.

The organisation of health services is believed to carry negative images, for example:

1. waiting time to obtain medical treatment is sometimes too long
2. hours of operation for the out-patient services are very limited
3. the health centre or hospital is large, crowded, confusing place
4. if a dispenser is absent from work, the dispensary remains closed for the day.

Cultural discontinuities may carry some negative images that:

1. health care workers are often unhelpful and rude
2. many of the health professionals in hospitals do not speak Ibo, Yoruba, Hausa or any other local dialect
3. diagnoses are made in a semi-public place with little or no privacy
4. much of the diagnostic questioning is overly direct and insensitive
5. the patient may be asked to undress and may be touched or handled during diagnosis
6. the ease with which men and women intermingle at health centres and hospitals is repugnant to devoutly religious Nigerians.

Credibility of modern medicine may carry negative and poor image, for example:

1. modern medical care is too expensive for the villagers
2. it does not acknowledge the existence of various but specific diseases that sometimes afflict a particular ethnic group more than others
3. the standard of medical care is affected by the shortage of qualified staff
4. bottle feeding for babies is recommended too often
5. caesarean births are more common than they should be
6. health care professionals generally do not acknowledge that traditional medicine is efficacious
7. specific medical practitioners generally do not admit their own limitations; they try to treat everything.

Quality of care may carry negative images for example, that:

1. many patients admitted to health centres and hospitals die
2. injections are frequently not given even though they are the appropriate form of treatment
3. instructions guiding the use of drugs or tablets are not usually given
4. fractured limbs are frequently amputated
5. overdilution of medicine with water make it worthless and ineffective.

Corruption carries negative image in terms of, for example:

1. to offer proper medical treatment, bribe may be asked for
2. one will be told that a particular medicine is unavailable when it actually is available
3. injected medicines are often diluted, or water is substituted for medicine, or the needle ("jag") is only inserted into the body without the medicine being injected
4. even if valuable medicine is prescribed the pharmacist may substitute useless medicine for it
5. widespread private practice by hospital employees proves that they are corrupt.

These uncompromising attitudes of the village people to modern health care make them also not to accept modern medicine. Maclean (1966) administered a health attitude survey/interview about the use of modern health care in a hospital in the rural areas of Western Nigeria. The responses she had showed mix-results, for example, a good number of people in her interview stated that no one in their family had ever been to a hospital - amongst these included prayer healing sects, traditional healers. When asked about the kind of diseases which they thought hospital could treat, people responded with great deal of variations, for example, many favoured traditional care instead, claiming that it was unnecessary to treat fevers with European medicines, rather, people should use their own herbal treatments which must include sapwood tree, bark, root or leaf, as well as special soap containing onions, a type of yam, and the plant of eru and dried leaves powder.

In the case of small-pox attack, people had different opinions regarding suitable medicine with hospital care. Greater enthusiasm was rather shown in treating small-pox with a particular ointment of 'ero-shoppana', odundum leaves, rinrin leaves and powdered snail shells which must be mixed into an oily base of palm-oil and shea-butter which are effective in the treatment and also reduces pock marks or scarring. Furthermore, a long incantation must be sung during the preparation of the ointment and an "ifa" sign made on calabosh containing these ingredients. Many other people interviewed, warned against the danger of washing a patient too soon just the way the hospitals and health centres do. Other people claimed that the importance of palm-wine should always be stressed both as the sole drink for patients and also as an offering to the 'Orisha shoppana god' who also appreciates offerings of beans cooked along with corn, while a good number of other people asserted that small-pox has a spiritual cause and only proper rituals of appeasement and incantations could have any real effect. Lambo (1982) however, tends to believe that ineffectiveness and inefficiency of health services in Nigeria are due to misallocation of the limited resources available and defective operational policies at the individual institutional level, especially at health centres and clinics. By application of optimization and simulation models, Lambo and his assistants tried to show or prove that with appropriate allocation of personnel to workers, the personnel mix at the health centre they studied in Nigeria could see thrice the current case load while their simulation model results showed that with better operational policies, the health centre of their study could see about 75 percent more people than had been the case, given the same personnel mix and size.

FOLLOW UP AND MONITORING

Follow-up and monitoring of patients' health conditions are important because these activities contribute to health maintenance once the patient leaves the health centre or hospital. Continuity of care, in terms of providers and information, is an important aspect of delivery of health services. Follow-up and monitoring however, receive little or no attention in most of Nigerian health care systems due to limited resources, hence efforts have rather been concentrated on direct provision of health services. It is widely believed that an efficient follow-up system and monitoring activities may be achieved in Nigeria if, for example:

- i) the ministry has a system of monitoring local health programmes
- ii) contacts are made with patients to see that recommendations are followed once they leave the health centre or hospital
- iii) a policy of ongoing contact is established where necessary
- iv) there is collaborative planning with the patient so that he or she knows who to contact for assistance, when to return for follow-up care, and what to do once he returns home
- v) the patient is forewarned of possible side effects that may result from treatment
- vi) patients are told of health symptoms which should alert them to return to seek care from the health care system

- vii) efficient co-ordination system between those doing the referrals and where patients are referred to is established. This is important to management because in areas of high use, it contributes to decreases in admissions and channels people to correct providers of care.
- viii) medical records are kept for all patients which must include general data and data for patient follow-up, for example, medical records for chronic cases. Another aspect of a good system, in say, alphabetical, numerical or chronological order.
- ix) confidentiality of medical records of patients are kept.

Also those traditional health practices that may be consistent with good modern health care should be encouraged, accepted; supported and closely monitored by say the Nigerian Medical Association. This may be, for example, in the form of studying those traditional practitioners currently in greatest use in the country, for example, the Traditional Birth Attendants (TBAs) and Traditional healers to determine how they can be used more effectively in a treatment role as well as referral of patients to appropriate sources of treatment outside the village.

Nutrition may be an important area for a follow-up and monitoring programme in Nigeria. If, for example, nutrition should be raised to the level of a national concern, a central governmental agency composed of representatives from a number of ministries should be organised in order, for example, to:

1. study the effect of nutrition on national development
2. design and implement studies to define further the extent and nature of malnutrition in Nigeria
3. plan and carry out programmes designed to educate rural women in the proper nutrition of both themselves and their children
4. re-evaluate current nutrition policy, particularly the distribution of food supplements, drugs etc through health centres, clinics etc
5. explore the use of mass media locally - radio, advertising, local group meeting etc to diffuse information and to motivate mothers to improve nutritional practice
6. re-activate farming and farm projects in the rural communities, as well as giving out loans to support the local peasants.

Under nutrition, especially amongst infants and young children is not only itself a major cause of disease and death (kwashiorkor etc) but is frequently an associated cause of other diseases, for example, underweight, slow growth, etc.

Maternal undernutrition can give rise to serious health problems, for example, difficult labour and birth injury. Interventions to promote health in Nigeria need co-ordination, follow-up and monitoring efficiency in order to control some major communicable diseases that prevail in the rural areas of the country - cholera, measles, tuberculosis etc and this co-ordination effort must be undertaken at individual, community and government levels to achieve positive results. Equally some follow-up and monitoring of the operations of community health centres, clinics, hospitals may be undertaken, for example: to assess primary health care effectiveness or whether doctors (or health professions) have:

- i) a suitable workload in their clinic sessions
- ii) access to a full range of diagnostic and treatment facilities
- iii) efficient arrangements for dictation etc.
- iv) whether patients are given:
 - a) friendly and helpful reception at clinic or out-patients
 - b) privacy and a satisfactory level of amenity
 - c) compact grouping of the facilities required for his visit
 - d) adequate or proper medical attention/treatment etc.

UTILIZATION OF HEALTH SERVICES

There has been need to record utilization rates for different health services that have been provided and services which may be over-used or under-used and the likely reasons for such developments. Health utilization exercises may include assessment of in-patient and out-patient facilities and community health services. In the Nigerian basic health services scheme, utilization of basic health services has remained low because of the negative attitudes of the village people to modern or Western type of medicine.

There are important factors which determine rate of utilization of basic health services in Nigeria - distance of the journey made before reaching the nearest health facilities., availability of public transport in the rural areas, availability of ambulance service, road conditions, mode of transport - bicycle, foot, donkey, financial costs etc. It is not always possible to have public transport in the rural communities and there are no provisions for emergency or serious illnesses.

Utilization of health services tend to be greater amongst the men than women in Nigeria because some men own cars, bicycles, canoes etc, while women are traditionally more dependent upon men economically, who also make most decisions about health matters in the family. Much more, majority of Nigerian women in the rural communities do not own cars, bicycles etc and this restricts their movements to seek health care and the facilities are considered relatively far away to reach on foot (walking). The studies by Stock (1980) revealed that in Hadejia of Northern Nigeria, relationships exist between distance travelled by patients and method of transportation, for example, that the proportion of patients arriving on foot declined with distance, while the proportions travelling by commercial motor vehicle and train increased and the use of non-commercial intermediate technology types of transportation was greatest in the medium distance of 2-10 kilometer zones.

Seasonal variations in Nigeria also affect transportation to reach nearest health facilities when seeking care. During rainy or harmattan seasons it is almost impossible in some Nigerian villages to use motor vehicles while in others a partial journey can be made by road in which bicycles, motor-cycles may be used through bush-paths. Some villages also have rocky mountains which are neither suitable nor comfortable for motorists or cyclists when seeking health care. Mobility is also restricted by extreme cold temperatures as well as excessive (sun) heat which not only affects humans but also destroys useful vaccines and drugs in several health centres and clinics where cold storage provisions are not available. In these excessive and extreme weather conditions, visits to health centres or hospitals are postponed on several occasions during the periods of greatest

risk, or somehow timed to avoid them or choose the favourable times (morning hours or evenings in the dry season or othertime the weather has improved). These seasonal variations of weather also affect farm-work and the local peasants' health as well, which in turn influence decisions to seek health care, for example, some local farmers in Nigeria are known to be very much occupied during the early part of rainy season in bush clearing, tilling of grounds and sowing of seeds and crops, replanting, weeding etc. These farm activities exert maximum pressure on farmers because of intense concentration of agricultural activities which affect their health. But instead of seeking health care when they fall sick within this period of farm-cultivation, many local farmers tend to delay seeking treatment to avoid any interruptions to their farm work. In the north, some Hausa peasants tend to believe that Allah the Islamic God naturally made rainy seasons sickness-free and this belief is not entirely from medical histories of Hausa people, but because work or farm-work makes it unimportant. Storey and Matsushima (1975) examined seasonal variations in the age structure of the user populations of dispensaries in Garki community in northern provinces of Nigerian and found that the proportion of children increased significantly at the end of rainy season. The study by Stock (1980) found that the proportion of children amongst Hausa patients in 1976 was greatest during the dry season and the harmattan when severe measles epidemic occurred and high incidence of post-measle complications reported in Hadejia, where in-patient attendance was about 40 per cent greater during the dry/harmattan seasons than during the rainy season. The reason for this according to Stock is that there was less agricultural activities during these seasons and people were willing to spare time to seek a cure for chronic complaints such as inguinal hernia, tumour etc.

There are several other factors that are considered applicable to levels of utilization of health services in Nigerian villages. The frictional effect of distance tends to apply unequally to the various age and sex components of patient population, for example, married women must obtain permission from their husbands before leaving the house for any reason, and have fewer options about how they may travel. Travel by younger children may depend on the availability of an adult to carry or escort the child to health centre or clinic to avoid exposing him to any danger. The elderly patients may find longer distances a significant of difficulty, if not absolutely barrier to obtaining the necessary treatment they need.

The level of service utilised and distance travelled may not be considered in isolation. Jolly and King (1966); and Schultz (1977) believe that people are willing to travel further for more specialised services or better quality care than for less sophisticated services. This they illustrated with the utilisation rates of Ugandan hospitals which halved for every two miles of distance, while aid post visits per capita were halved each mile; while in-patient visits halved every three miles. Similar studies have been carried out in Nigeria which confirm that the impact of distance on the rate of utilization of services is strongly related to the quality of services being offered and also strongly related to the seriousness of the illness. People are willing to travel much further for the treatment of relatively serious illnesses requiring in-patient care than for less serious ones amenable to outpatient treatment, providing they have the means and finance to pay for them especially in the Southern Nigeria where patients pay for health services while free in the North as a whole. Similarly, the hospital and rural health centre, with more comprehensive supplies of medicines and larger staff (in some states) are much more successful than the medicine-

short and under-staffed local health authority dispensaries in attracting medium and longer-distance patients. People are hesitant to travel several kilometres to a dispensary knowing that it will be closed if the dispenser is absent; and that there is a high probability of the supply of injectable drugs being exhausted.

Based upon seasonal variations and weather conditions, patients age and sex, quality of services available etc long distance to reach the nearest health facilities tend to cause village people to delay seeking treatment,, abandonment of treatment regime. Thus far distance tends to have a delaying effect amongst people seeking treatment. Equally some of the distance-related disparities in the promptness of seeking institutional treatment are sometimes accounted for by differences in the types of sickness to be treated, for example, the proportion of chronic illness may be greater amongst patients who are prepared to travel or who travel greater distance to seek treatment if they have the means - costs, transport, time etc. Discontinuation of treatment amongst majority of village people may also be distance-related when course of therapy is abandoned or terminated prematurely before the prescribed date. However, discontinuation of many other treatments may be due to complete or successful cure having been obtained: there is no follow-ups to find out if a patient is cured. On the other hand, lack of any improvement of one's health problems after days of treatment does not encourage the person to continue with treatment and for those who travel far distance to seek medical treatment, if they have no visible signs that there are some improvements, continuation of such therapy is simply a waste of time and money.

When the journey to reach the nearest health facilities are short, many Nigerian patients who live nearer to these facilities tend to over-use them, especially if the quality of care given is good. Over-usage may also be as a result of certain patients (for example, students, workers etc) wanting to seek health care almost every time to evade some of their educational or social responsibilities and obligations. They may for example, absent themselves from lectures, work etc during attendance at clinics and in this way abuse the real need for genuine health care. Some of them may resort to wasting of health resources, for example, by not actually making use of drugs prescribed for them, wasting the time and efforts of medical profession, denying genuine patients their rights to have these resources instead. The reason for over-use of health facilities by some students and workers, is that they are medically treated free. In the case of some workers, their employers meet their health care costs, while students are known or recognised to have no or limited income.

The other factors that can be considered in relation to levels of utilization of health services in Nigeria in general must include the following:-

1. The level of education of the people which stimulates consciousness for treatment.
2. Severity of illness, which forms the urgency for a patient to go for treatment.
3. Socio-cultural attitudes which are found in the population served.
4. Cost of treatment which can form an obstacle to the people going for treatment.
5. Geography - mountains, islands, riverine and waterways, forests etc - can determine visits to reach health facilities.

6. Distance between the home of a patient and the place of treatment.
7. Mode of transport: bicycles, horse, public transport etc.
8. Population density served.
9. Quality of service which are given to the people.

In Nigeria, level of utilization of health care may also depend upon the type of illness management process adopted by both medical profession and the health management alike in terms of medical treatment methods or decisions taken on resource allocations. Studies of illness management usually employs a social psychological framework as shown by Suchman (1965) as well as the nine stage economic model of illness behaviour developed by Fabrega (1973). Fabrega's model ranges from illness recognition and labelling etc to selection of treatment plan. Igun (1979) on the other hand, criticised Fabrega's model because of its scant attention to the socio-cultural context of health seeking behaviour and social meaning of illness. Igun criticises Fabrega's model also as being incapable of dealing with the role of family and friends in health-seeking and then proposed an alternative stage model of sickness behaviour within African context which ranges from symptoms-experience, self-medication/self-treatment etc. to recovery and rehabilitation activities.

1.9 ALTERNATIVE FORMS OF CARE

Traditional medicine is an established part of Nigerian culture and tends to remain the only source of care for majority of Nigerians and for them primary health care is synonymous with traditional medicine.

The traditional healers play an important role in their respective rural communities in Nigeria as they are able to treat some of the people's common ailments and mental disorders, and for several of these communities the healers constitute the core of primary health care workers. The authority of many Nigerian traditional healers is substantially derived from their recognition in and by the rural communities in which they live and practise. Their dress, calm and authoritative air and other personal qualities all contribute to effective treatment.

Techniques in healing vary according to the style and practice of individual healers, and these may range from meditation and relaxation, induction of trances and exorcism, rituals involving dancing, incantations and prayers; to offering sacrifices and application of herbal medical remedies of either animal or mineral origins or both. Some of the healing practices are believed to be helpful in counteracting the growing tension and emotional symptoms such as changes in mood unconnected with outside events; appetite changes; changes in sleep patterns; guilt feelings; aggressiveness, obsessive behaviour; loss of control over thinking in which strange ideas keep coming into one's head (fears, poisoning, suicidal tendencies); panic attacks; loss of sex drive; constant fatigue; strain and stresses of modern life etc.

In Nigeria, the vegetable kingdom has become a treasure house of potential drugs and the story of herbal medicines has become a fascinating one. Quinine, until recently was the only effective remedy for malaria. There are other herbal remedies that are well known, for example, morphia the painkiller; digitalis for the failing heart; emetine for amoebic dysentery; ergot for midwifery practice, ranwolfia the tranquilliser. Lunacy antidote

and hypotensive agent were all well known to the healers and medicine-men of Africa many centuries long before their introduction into modern medicine. In oncology (the scientific study of neoplasms), podophylotoxins, the vinca alkaloids, colchicines and some anti-biotics have been derived from local plants traditionally. Several Nigerian practitioners of traditional and indigenous medicine rely mainly on medicinal plants and herbs for preparation of therapeutic substances. Many of these traditional healers still believe very strongly that the plant kingdom is and must remain the source of food people eat and the oxygen they breath and therefore can be capable of providing for the whole mankind the medicine(s) of the future. Following this assumption, there has been in Nigeria recently, some re-awakening of interest in the potentials of plant products and some research scientists and drug houses are now giving considerable attention to the study and development of plants with known medicinal properties. With such information available as a starting point, these scientists may proceed to isolate active elements and synthesise modifications in the hope of producing more effective substances than the original natural product. Diurnal variations in the yield of active principles have been shown in several plants in Nigeria and this has also been common knowledge to some healers and herbalists in the country for long, examples being morphine and atrophine whose yields in the morning are about four times the yield at night. But the active principle varies with the stage of germination, and variations occur also in the constituents of the same plant species and in different climatic and soil conditions between the drier northern Nigeria and the wetter southern regions.

The majority of elders, and most certainly the healers in the Nigerian rural communities tend to have considerable knowledge of herbal medicines

which may be applied generally in the treatment of common ailments and when Nigerian primary health workers do not seem to possess such knowledge, confidence in them cannot be established effectively. Nigerian primary health workers have therefore been encouraged to have interest in the study of cultivation, collection and preparation for therapeutic applications of the common medicinal plants. Without sufficient knowledge it would be difficult for Nigerian health workers in general to have a clear insight into what community members do for themselves in times of sickness. There can be up to four main categories of traditional practitioners in Nigeria (i) those who have received a fully integrated training in modern and traditional systems of medicine (ii) those trained mainly in traditional systems of medicine but who also have elementary knowledge of modern medicine. Such health workers practise mainly in smaller rural communities, using traditional medicine in general and modern drug administration especially in emergency situations. The example of this category of health workers are known to be working with Lambo's Psychiatry at Aro Village; (iii) the traditional practitioners without formal training but who inherited traditional healing techniques from their families or kinsmen and (iv) the traditional practitioners who acquired their skills and knowledge through years of apprenticeship with an established traditional practitioner. These include traditional midwives and some herbalists.

The integration of heterogeneous groups of fully trained, half trained and untrained practitioners into Nigerian health care system officially poses many problems as has been widely debated in the country as a whole. The first group of the traditional practitioners mentioned above may perhaps be the ideal practitioners in Nigeria since they generally seek out and utilise

the best practices in both integrated training in modern and traditional systems of medicine. The second group are equally manageable administratively. They practise almost exclusively in rural areas and some have been engaged in family or government clinics with some satisfactory results. Integrated practices have also been introduced in some Nigerian teaching hospitals - Institutes of Health (ABU) Zaria, University of Nigeria teaching hospital, Enugu Campus, Ife University teaching hospital etc, where these traditional practitioners work alongside modern physicians and employ traditional remedies including herbal medicines. Their main functions have been in the curative aspects of health care, but preventive and community health practices are inculcated through in-service training. The third and fourth groups have no institutional or formalised training and therefore pose many problems which necessitate some form of preliminary orientated courses and in-service training for them before any form of integration may be considered within Nigerian health care delivery system. The traditional midwives in Nigeria however, constitute a special category. They form the main body of primary health workers in maternal and child care, and in some Nigerian rural areas they are responsible for over 90 per cent of births. However, many people in the country tend to recommend phasing traditional midwives out of service and replacing them with fully-trained professional midwives working in close collaboration with obstetricians, but due to several socio-cultural constraints and beliefs of village people, such hope still remains futile and untenable. The only possibility of extending and improving maternity services however, seems to lie in giving orientation and training to these traditional midwives regarding safe and hygienic midwifery, and with adequate supervision and referral facilities. Most of Nigerian traditional midwives are intelligent and highly motivated elderly women though the vast majority of them are

illiterate also. They practise in the rural areas where age and experience command much respect and prestige.

Horton's view (1967) is that traditional medicine beliefs are internally logical when assessed within the context of the culture of which they form a part. WHO (1976) claims that there are positive and negative impact of traditional medicine on health protection and promotion in Africa.

Schwartz (1969) believes that European medicine is incapable of dealing with illnesses caused by sorcery, moral lapses, spirits (etc). However Dunlop 1975, Taylor 1971 argue that there is considerable interest in the possibility of functionally integrating traditional healers into the health care delivery system. Good et.al (1979) argued that such an integration is long overdue while Asuni (1979) believe that hasty decisions to staff primary health care schemes with traditional healers may have unintended consequences.

It is believed that a careful review of the various traditional practices in Nigeria is long overdue just as the review for appropriate objectives for training these knowledge, skills and terminal behaviour is also very much needed. Any training programmes for Nigerian traditional midwives should constantly make reference to local body of beliefs and practices relating to, for example, the entire maternity cycle of puberty, pregnancy, child birth, post-natal period and child-care. The debate whether traditional medicine should be recognised and practised officially in Nigeria to complement the shortage of medical personnel has been going on for some time amongst several individuals especially between the officials of the Nigerian Medical Council and the Traditional Medicine Board of Nigeria.

Following the persistent demands by the Nigerian herbalists with moral support from some parliamentarians and some university dons, several state government administrations and the federal ministry of health are in the process of mapping out programmes of recognition for traditional medicine, for example, establishing boards for effective supervision of the practice of traditional medicine and the best way to unify, modify and update it.

The debate whether, or not to accord traditional medicine an official recognition has always fallen into two main camps in Nigeria - those in favour and those who are against.

The people that argue for an official recognition of traditional medicine claim that for long it is known that traditional medicine had kept a large segment of the population alive prior to the advent of modern medicine and that some of the therapeutic regimen employed by some traditional medicine men in various parts of Nigeria do indeed contain ingredients that have scientifically proven effective against the diseases for which they have been used. They also believe that Nigerian traditional doctors have a surer way of prolonging dying-patients lives in order to give room for further treatment. According to the Chairman of the Traditional Medicine Board of Nigeria (1980), this is done in the form of a ring or belt. They also claim that spirit atonement and incantations are part of traditional therapy and are effective. Furthermore they stress that it is a sheer waste of time to analyse the active substance of herbs because sometimes the ingredients have no relevance to the disease it cures and that herbal drugs must be used as prepared by the traditional doctors with little modification involving preservation and sanitation.

The people who are opposed to an official recognition of traditional medicine in Nigeria claim that traditional medicine is not one science, but a collection of individually evolved practices developed in different Nigerian families over generations and transferred to a limited number of people by apprenticeship. The practices are as varied and divergent as there are traditional practitioners and also as different in form and substance as there are ethnic groups in Nigeria. It is therefore difficult in such circumstances, they argue, to talk of traditional medicine as if it is one entity. Further opposition surrounds the lack of scientific grounding of the practices and no systematic practice based on thorough knowledge of human anatomy or the symptoms produced by human organs as their physiology is disturbed by a particular disease. While it is true that active ingredients have been extracted from some herbs used by the traditional healers in Nigeria, opponents say that it is also true that co-existing with these active substances are dozens of other substances that have no relevance to the disease being treated and in some cases may be injurious to patients.

However, there are many Nigerians involved in the debate of recognition of traditional medicine in the country who tend to take middle line without committing themselves to "a yes or no" answer but have rather offered some suggestions relating to the need for:

1. The setting up of State Boards to control traditional medicine. The composition of such boards comprising, for example, reputable native doctors, medical doctors, pharmacologists, pharmacists, who will oversee the improvement of the practice and its absorption into the Nigerian health care system.

2. The various Nigerian governments looking at traditional medicine from proper perspective devoid of all unnecessary cultural or individual constraints.
3. The setting up of a high level commission including representatives of the Nigerian Medical Council; Nigerian Medical Association; Association of Traditional Healers; Pharmacologists; Health Economists, Legal Practitioners to study exhaustively the whole issue of traditional medicine and make necessary recommendations on the best way to unify, modify and update it if and when eventually integrated with Nigerian modern health care delivery system.
4. Creation within States ministries of Health, traditional medicine inspectorate divisions headed by medical doctors whose functions would be to get into the fields and monitor the activities of native doctors, to make sure that only registered practitioners actually practice, that the practice is done under hygienic conditions and that no harm is done to the public and also to evaluate therapeutic effectiveness, standards or quality of traditional health care in general.

1.10 COMMUNICATION AND EDUCATION ABOUT HEALTH SERVICES

Communication plays a key role in preventive health measures, participation of rural communities in health activities and work of primary health workers and auxiliaries.

Associated with the principle of prevention, in Nigeria is more realistic as an economical health strategy than curative measures for greater numbers of Nigerians. While curative approaches tend to lessen the harmful effects of disease, prevention lessens the incidence occurring in the first place.

The Nigerians Preventive health plans imply not only providing resources such as vaccines, nutritious foods, materials for developing sanitation facilities, but also addressing the problem of people's inclination and ability to use these resources to the best advantage. However, the Nigerian experience tends to show that many village people in Nigeria fail to use readily available help for their health problems, for example, vitamin A deficiency persists in several Nigerian rural communities even though vegetables with abundant vitamin A are readily available everywhere. Some health facilities (health centres, clinice etc) remain unused or partially used, even when the basic services being provided are good (in other times the services are bad).

The problem of malnutrition in some parts of Nigeria is attributed to poverty of knowledge rather than economic or financial poverty. However the situation requires dedication and genuine efforts on the part of Nigerian health education and communication experts to persuade village people and convince them to understand the main reasons, why it is important for people to practice preventive health habits. But critiques tend to maintain that the Nigerian health education programmes have been sterile, underfunded and recieve low priority from the governments. Furthermore, it is observed that Nigerian doctors who work at health

centres tend to consider health and nutrition education not seriously as part of their work, while in other situations, many health workers who have some health education responsibilities in Nigeria do not have the right attitudes, knowledge, time or back up support to do it properly. Also, they lack enthusiasm and spirit to promote preventive health programmes through health education.

Many suggestions have been put forward that health education and preventive health programmes might be effective in Nigeria if, for example, primary health workers and other medical auxiliaries are provided with tape recorders which can be used with community groups. These tapes can bear the burden of presentations with the primary health workers and used for feedback to project officials, and if a library of tapes can be prepared, some of the village people may decide to select their own topics without being totally dependent upon health education experts and other health workers, or on the perception of an outside official as to what is important.

The second suggestion that has been put forward relates to radio broadcasting and its impacts on health education. Although radio broadcasting in Nigeria reaches many parts of the country, it is observed that radio broadcasting in Nigeria does not take sufficient interest in taking on simple health educational programmes nationally or locally in which talks, interviews or short plays are specifically patterned to reach local communities. In such radio broadcasting activities, doctors would be requested to be involved and agree to be interviewed or talk on a cassette recording etc as Nigerian doctors have always had considerable authority and creditability to support, or influence health projects.

Other suggestions made include that health education activities could be carried out in such places like the waiting-rooms of health centres, out-patient clinics etc as there is a great opportunity to use waiting time not only to provide information and education, but also to make the clinic visit a far more positive experience for many out-patients in attendance.

This may be done in several ways, for example, by playing recordings of Nigerian dramas (or any other acceptable one) on family planning in the waiting-rooms to be supplemented with some illustrated booklets, about health prevention schemes relating, for example, worms, diarrhoea, malaria, etc. However, efforts are continuing in Nigeria to advance health education and preventive measures through use of role playing, case studies, demonstrations, songs, dance, drama etc. The example of role playing has been illustrated with the Nigerian film: "That Our Children Will Not Die" - which was produced by the Institute of Child Health in Lagos (1981) in a largely preliterate community where song, dance and drama are the primary educational media: these media are used to train local health workers, who use them in turn to teach the villagers about such health problems as shistosomiasis, tuberculosis and malaria.

HEALTH EDUCATION: Primary health workers and their health teams can effectively promote health education in the village. Health education properly exercised, can achieve a great deal, even in the most desperate situations. All health workers in Nigeria are encouraged to provide health education while providing services. King (1966) claims that health education is a function of all the staff and that the aim of health education is to alter behaviour where it causes disease. All appropriate media should

be used and special attention given to rural and underserved areas. Simple explanations of factors helping the local spread of disease and ways in which the villagers can help interrupt transmission will secure community involvement and minimise panic.

In Nigeria, emphasis on personal hygiene, especially hand-washing with soap and water and on food and water safety is essential. The necessity for eating cooked food and drinking safe water - boiled, treated, or collected from a safe source and stored properly - should be explained. The need to protect all water sources from contamination must be emphasized; infection is acquired not only by drinking unsafe water, but also by bathing or washing articles at contaminated sources. The Nigerian local communities should also be informed about the dangers of:

- i) Community feasts and gatherings of any kind, particularly funerals, where safe food and water and proper excreta and waste disposal cannot be assured
- ii) Visiting sick relatives and eating and drinking in the homes of cases
- iii) Contaminated foods, for example, vegetables irrigated or freshened with sewage-contaminated water.

Provision of safe water is very important, as the boiling of water is not practicable in many situations. Numerous simple and innovative methods are available for the supply and treatment of water. Special attention should be paid to the proper protection, storage and use of water in the home. Winblad and Torsternson (1978); Mann and Williamson I.T.P; all claim that it is especially in the areas of housing, water supplies, excreta

and household disposal that new cheap effective and locally available materials and methods are required. Many other studies have been done on rural water supplies and sanitation in less developed countries (White 1974), (Feachem, 1978) and so on.

Proper disposal of excreta is vital to protect water sources and the environment. In the absence of any facilities, burial of all excreta, especially those of cholera cases, is essential, or other methods should be ensured to prevent flybreeding.

Experienced field workers suspect that community organisation is a key element in bringing about behavioural change and this cannot be achieved through the mass media alone without local involvement. Village based health workers are the most effective carriers of educational messages at household level but they need co-operation from both the mass media and community leaders in setting up local programmes to deal with preventable diseases. Disease control programmes should include not only environment improvements but also the provision of resources for effective disease therapy, together with the encouragement of local evaluation procedures designed to maximise scarce resources at various local intervention stages.

Health education has to be directed to prevention of diseases. Preventive measures should be concentrated upon: nutrition education; improving environmental sanitation and modifying personal habits; immunization; routine examination of ante-natal and under fives clinic (etc). In nutrition education, for example, mothers should be taught or given lessons of practical value: for example:

- i) Encourage breastfeeding for the first six months - cheap, clean, easy. Bottlefeeding is often a status symbol but has two main disadvantages: a) bottles are hard to clean-infection, gastro enteritis, malnutrition b) Milk powder is expensive. In order to ensure that the milk will last long time, the milk is often too diluted.
- ii) After six months the child should come on a transitional diet of gradually increasing locally available, soft, digestible foods with sufficient protein and vitamins not less than 4 times per day, leading gradually to a balanced diet with sufficient protein and vitamins of an adult-type.

Health education should also cover the question of how to obtain necessary foods - agriculture, livestock, fisheries (etc) and how to prepare them: home craft. Close collaboration with the departments of agriculture and community development authorities is vital to successful nutrition educational programmes.

Nutrition education has to embrace: change in knowledge, change in attitudes, change in habits, change in customs; all these leading to:

- i) knowledge and acceptance of new ideas
- ii) increased food production and availability
- iii) improved food habits
- iv) improved nutritional status of the whole members of local community.

A change in habits is important and desirable because certain forms of behaviour have become a habit and are no longer a conscious decision. In the same manner, a change in customs is vital because certain habits have become a cultural characteristic.

There are many other areas where complete questionnaire may be drawn for nutritional education, for example:

- i) local home economics - type of kitchen, fuel, utensils; available funds
- ii) local methods of child feeding - length of lactation period, at what age are solid food given to a child; are milk, milk products, legumes, eggs, meat and fish given at all, and in which quantities, is bottle feeding practised?
- iii) cultural factors: food taboos - number of feeds daily, feeding order in the family especially as father sometimes is given priority (etc).

COMMUNITY PARTICIPATION: In the Nigerian 'Lardin Gabas Rural Health Programme' Community participation began with a 'sensitization' of the community to its needs, often prompted through a personal visit by someone from outside the community. This is proved to be a slow, deliberate process. Experiences in the People's Republic of China, Tanzania, and elsewhere, for example, suggest that the process might be accelerated by using mass media to encourage and orchestrate participation in health and health-related programmes. If this method is adopted in Nigeria with some careful planning, radio broadcasts and radio bulletins can persuade majority of Nigerians to be convinced that better

health is possible by people themselves planning and taking active part in health matters and decision-making process. This method can also be tied into organised community groups - mothers' clubs, co-operatives etc, to stimulate and guide basic health activities and actions. Publication and other communication materials might be used in co-ordination with radio broadcasts.

PRIMARY HEALTH WORKERS AND HEALTH AUXILIARIES' TRAINING

These para professionals play very important role in basic health activities in Nigeria but their use in several health development programmes is often plagued with problems. Training programmes for Nigerian health workers with support of mass media can reduce these problems, but hopes to develop effective training materials through the media have been dashed as they have not for example, been supported with tapes which contain information that can be taken home.

This may reinforce training and introduce new ideas and techniques in health workers' jobs. Audio cassette system may also help rural health workers' training, being often easier to use, especially if literacy is a problem in their rural areas. Audio cassette system permits the use of drama, interviews, talks and stimulates discussion to convey points effectively. Furthermore, repetition is easy, and the system itself is relatively inexpensive and durable. However, although good and continuing training is important for these health workers and para professionals, it is by no means a substitute for proper pay and suitable material support for them but these can be combined with some explicit communication strategies to make health education and preventive measures more constructive.

The aim of health education is to persuade people to adopt and sustain healthful life practices, to use health services available to them, and to improve by themselves - individually and collectively - their health status and environment.

It is well recognised that the attainment of changes in health behaviour of Nigerians is conditioned by social, psychological and economic realities and by the amount and quality of available health services. It is not an easy process to educate people to change their health behaviour or to improve their environmental conditions. Some social and cultural characteristics of the population can present serious barriers to the achievement of change in health behaviour. In Nigeria these characteristics amongst others, include low educational level, traditional dependence on government to solve all problems, low opinion of the government employees and unsound health beliefs and practices rooted in superstition and folk medicine.

Health education should always be based on a sound knowledge of the socio-cultural context of the community and on a thorough knowledge of its relationship with local health problems. While the services of a health education specialist are desirable at every level in Nigeria, all health workers should have continuing opportunities to develop skills in the use of health education methods and should never forget that they all have health education responsibilities. Every effort should be made to get, for example, school teachers, social workers, agricultural workers, community development officers etc to contribute to the health education effort. Communication media used for health education must be chosen to suit the cultural orientation of the people of Nigeria: drama, singing, films and

other similar methods of communication have proved to be effective channels in communicating health ideas and desired health practices as already mentioned in the film "That Our Children Will Not Die". But person-to-person contact and group discussions could be the most effective and direct way of reaching majority of village people in the country.

1.11 PRIMARY HEALTH WORKER IN NIGERIA

Many writers have stressed the importance of re-orientation of health workers in general, but more importantly the re-orientation of the auxiliary and primary health workers in primary health activities so that the basic health needs of everybody, especially people in rural areas can be met. Smith (1978) claimed that the broad based foundation for a primary health care system is a variety of appropriately trained and deployed persons to deliver services integrated at community level. Joseph (1976) has a similar view when he identifies two main approaches to providing personnel for basic health care provision in the rural communities. He believes (1) that the development of local health systems that depend on non-physicians to provide the major part of primary health care is vitally important. This in his view is especially useful in areas where manpower and financial resources preclude or restrict the availability of physicians - a point which had earlier been put forward also by Gish (1970).

Secondly, Joseph believes that the development of a team framework in which various types of health workers, including physicians, interact in a mutually supportive manner to maximise efficiency and effectiveness and to extend the reach of services to all rural communities is also very necessary in primary health care development as has been observed in a

number of countries, including China (Sidel, 1973); Iran (Rahnema, 1974); Ghana (Newmann, 1974); U.S.A. (Smith, 1973) etc.

In Nigeria however, efforts are continuing to provide adequate financial and material resources to increase the number and quality of primary health workers and other health auxiliaries who serve in the country's deprived and rural communities. The Nigerian primary health worker's profile can be explained under the following headings:

1. Organisation Structure
2. Definition
3. Selection
4. Training and Evaluation of Training
5. Functions
6. Role
7. Supervision
8. Salary and Remuneration
9. Problems.

ORGANISATION STRUCTURE

There has been no systematic organisation structure for the Nigerian primary health workers except the existing old organisation structure that was established mainly for the dispensary workers and clinic attendants in some parts of Nigerian rural communities. The reason for lack of efficient organisation structure for primary health workers in Nigeria is partly due to differences in states basic health policies and partly due to differences in health needs as well as differences in communities' health priorities.

Because of this inadequate organisation structure, primary health workers and health centre staff in Nigeria have tended to work according to their own wishes, this making coordination between the poly-clinic, maternal and child health, health centre and primary health care activities too difficult to achieve.

Primary health worker in Nigeria has been given different names and these include: refrained traditional birth attendant; household family health worker; local environment and development worker; trained community health nurse or midwife; community health aid; community health assistant; medical assistant; community health workers etc. Sometimes it becomes confusing if one group of primary health workers are not part of members of other groups - but essentially this is a problem of definition of who the primary health worker is. But whatever name has been given to him or her in Nigeria, one fact is established - every Nigerian primary health worker has had full primary education and undergone 3-6 months training course in primary health care and health education programmes, after which they were deployed in their various local communities. It is easily observed from this confusion about the definition of primary health worker, that the country has not yet achieved or developed a nationally accepted concept of primary health care itself and far from reaching a concensus on what the job analysis and job specification of a Nigerian primary health worker should be. Furthermore, every state has the right to develop its own primary health care strategy independently without recourse to what others may be doing and hence has the right to choose any name that is more appealing to their basic health establishments.

BUT WHO IS PRIMARY HEALTH WORKER?

- i) From the on set, he or she is supposed to be not necessarily a member of the conventional health service staff: a doctor or a nurse, rather, he or she must be a villager selected by his or her community and trained locally for a short period of time in primary health care activities
- ii) The primary health worker is a man or woman who can read and write and is selected by the local community authorities or with their agreement to deal with the health problems of individual people and the community at large.
- iii) Primary health worker is an indigenous member of the community and paid by the community or rural health authorities to provide primary health services to rural populations of his or her community.

ROLE AND FUNCTIONS

The role of the Nigerian primary health workers may be classified under three major headings (1) preventive, and health promotion activities (2) curative activities and (3) administrative activities.

PREVENTIVE ACTIVITIES: The PHW's preventive, rehabilitative and health promotional duties cover a wide range of activities, for example,

1. improving environmental sanitation by encouraging and assisting in home improvement, ensuring that villagers maintain clean compound, have an organised system of rubbish disposal, build for each family adequate and permanent dwelling homes, build latrines and educate them about their use; helping to improve quality of drinking water, destroying insect breeding places etc.
2. engaging in malaria control
3. conducting nutritional education and giving advice and assistance on how to grow nutritious, high yielding crops, food storage and food preparations
4. making home visits for follow-up care
5. discussing family planning with the community
6. reporting outbreak of disease early.

CURATIVE ACTIVITIES: The Nigerian primary health workers undertake several curative activities also. They recognise and provide first aid care to patients and help those requiring more skilled medical and nursing care for abdominal disorders, fractures and complicated maternity cases to obtain treatment through a referral system. They also provide other curative services, for example, they are able to

1. treat patients with malaria
2. offer and initiate life saving procedures through first aid

3. conduct a normal delivery of a baby
4. provide anti-natal and post-natal care of mothers
5. treat simple diseases such as diarrhoea, common cold etc.
6. dress wounds
7. encourages and co-operate with traditional healers to improve hygiene and better care of patients etc.

ADMINISTRATIVE ACTIVITIES: The administrative role of primary health workers in Nigeria include the following activities:

1. Keeping records of patients: age, sex, diagnoses and treatment etc.
2. Receiving and distributing drugs in communities.
3. Recording information on the community's sanitation progress: latrines kept in good order, germ-free and tidy kitchens, refuse disposal methods etc.
4. Registering pregnant women, births, deaths etc.
5. Writing of comprehensive reports of health events and undertakings in the community for local health authorities and supervisors.
6. Assisting the community in its self-analysis studies and discussions.
7. Co-operation with Community Health Committee in matters of referrals and referral system, organising community for immunization
8. Recording details about traditional healers and traditional birth attendant's progress in seeking improvement in standard of care and hygienic conditions

9. They also help to screen people against endemic and epidemiological disease and give some emergence care in cases of accident, snake or dog-bites, burns, drowning, accidental poisoning etc.
10. They raise the skill of village people to deal with minor health problems themselves (mild diarrhoea, disinfection of minor wounds etc).
11. They give care and advice, in accordance with the instructions written down in the guide or given by their supervisor, to anyone who consults them
12. They make regular report to the Local Health Authorities about people's health conditions in the community.
13. They promote community development activities and play active part in them.

Although the ability of every Nigerian primary health worker may depend upon such factors as his or her age, experience, education and training received, co-operation from village people, wages and salaries, etc, it is observed that a primary health worker does his or her job better if he or she is properly equipped with certain basic materials such as small first aid chest, containing variety of items for example:

orally administered drugs

chloroquine, in tablets or liquid form

aspirin; tincture of belladonna;

concentrated saline solution for preparing rehydration fluid;

Antiseptic soap for treating wounds;

Mercyrochrone;

Chloramine in tablets which can be used also to prepare dakin solution for treating wounds;
some cotton wool and bandages etc.;
some camphroated ointment or lehtyol;
a medical thermometer;
a pair of Kocher's forceps;
a metal goblet;
a metal plate;
a soup spoon and a tea spoon;
a bottle of one litre for Dankin solution;
a notebook for entering names of patients;
a notebook for the monthly order of drugs;
certain substances for sale: small DDT powder flasks for use as household insecticide (this can only be sold to villagers who understand or can understand the conditions and directions for its use).

SELECTION: The criteria for selection of primary health workers in Nigeria vary from one local community to another in the rural areas. However, there seems to be little disagreement amongst all the states that the men and women who work or employed as primary health workers must possess some specific qualities as described by (Warner, 1979). Selection of them in Nigeria is considered from various important aspects but mainly this is based upon:

1. primary health worker's acceptability to his or her community
2. degree of his or her motivation to primary health activities and interests shown

3. the leadership qualities possessed
4. basic education acquired
5. permanent residence of the primary health worker in his or her village
6. thorough knowledge of the customs, beliefs, values, traditional practices etc of the village people.

It has become a common practice in Nigeria that primary health workers are suitably selected by their rural communities and/or village health committees with some technical advice and guidance from doctors and health centre staff.

It is also observed that in some states, selection of primary health workers is the responsibility of their local health authorities while in few others, the state Ministry of Health has some role to play in the selection process.

TRAINING: The training programmes for Nigerian primary health workers are undertaken, at least, at two main levels:

- (i) training in the rural community
- (ii) training at health centre
- (iii) training at school of Basic Health Technology.

TRAINING IN THE COMMUNITY:

Although the length of training period which the Nigerian primary health workers undergo has not been federally standardised and unified, it is observed that their initial training on average is about 6-8 weeks. The nature of their training in the villages has always been of practical kind, which is given near their individual homes. Classroom lectures while important in their own rights are kept to a minimum.

The training instructions and guidance are given by supervisors who are also responsible for further training sessions of the primary health workers in between times or as one may like to call it, on-the-job training for them to acquire a more indepth skills and practical experience in primary health activities. The training in the rural communities involve collecting and analysing health information about the villages, for example:

1. the number of household with usable pit-latrines, rubbish collection pits etc.
2. indicating number of types of dwelling ... houses, the nature of compound, number of people per house/room etc
3. marking the water points, distance travelled to fetch water, state of drinking water, water usage
4. traditional healers and traditional birth attendant's role in the communities and their relationships with village people
5. types of crops grown, foods consumed locally etc.

In Nigeria as a whole, more emphasis has been stressed on the vital importance of primary health workers' training experiences to include the

full understanding of the village and the people. In this way they would be fully able to understand, for example,

- how a community works;
- who are its leaders;
- who has influence;
- the traditions and customs;
- who takes care of the people when they fall sick etc.

The Nigerian primary health workers are mainly receiving training instructions in groups with the obvious advantage of learning to work with others as a team, for example:

- i) in terms of illness, working with a community nurse or medical assistant, a doctor and specialist in public health or indeed, a primary health team
- ii) in terms of drought, famine, or poor harvest, working together with village council officers, community development officers, agricultural assistants, advisers and rural peasants
- iii) in terms of dirty well, working together with sanitarians, health inspectors, water technicians and installation specialists, water treatment personnel etc.

Group training is also seen as a way of developing one's potential in acquiring skills in decision-making, debate, discussion, planning etc procedures.

HEALTH CENTRE/CLINIC TRAINING

PHWs also receive Health Centre/Clinic training which equips them for their role in their communities clinically or otherwise. The contents of their health centre/clinic training are varied and include the following:

- i) Personal and community hygiene
- ii) Environmental sanitation
- iii) Knowledge of construction skills for digging of wells, water pumps etc.
- iv) Physical examination for simple diagnosis
- v) Maternal and child health and family planning methods
- vi) Simple methods of record keeping and compiling medical statistics medical records and preparing reports
- vii) Communication skills in interviewing, etc
- viii) Referral system
- ix) Communicable disease control
- x) Nutrition and ways of improving food production
- xi) Human relations etc.

TRAINING METHODS AND TECHNIQUES

The training package that has been developed for some Nigerian primary health workers incorporates group learning techniques and methods, leading to sharing of views and experiences, developing communication skills, stimulating others to talk, developing a feeling of confidence, participating in decision-making process etc.

The importance of group learning is particularly relevant to the training of Nigerian primary health workers as this method of learning allows access to health information about communities from collective experience of the trainees themselves and their efforts to practise teamwork and group discussions.

The Nigerian experience in training primary health workers suggests that three communication patterns play a significant part for efficient training sessions and these include role playing, case studies and practical demonstrations. It is also realised that primary health workers in Nigeria perform different functions than do hospital-based hospital workers. Because of this the primary health workers in training require a different kind of training in the use of simple techniques to communicate new knowledge and health behaviour in addition to basic clinical skills in primary health services, a view which is shared by Cole (1979), and Fugelsang (1979); respectively.

The Nigerian ideas about use of role playing, case studies and demonstrations are particularly useful as training techniques for primary health workers are developed from native song, dance, drama, folklore, proverbs etc. The idea is to be able to encourage and teach primary health workers to use these methods and techniques to communicate with the village people more readily about health problems and how to prevent and control them.

There are now fresh views that within the contents of the Nigerian primary health workers training package, there is some scope for the use of simple audio visual techniques such as flannel graphs and posters to be used to

some good effect being specially built or based upon cultural variations and understanding of particular tribal or ethnic groups (Ibo, Hausa, Yoruba etc). Furthermore many primary health workers training centres in Nigeria tend to suggest also that such media as films, slides and videotape could easily be used in PHW training programmes. But others tend to argue that this could prove to be economically wasteful and financially too expensive.

Case-study presentations in primary health workers' training in Nigeria involve community members also and depict locally relevant situations and in this way encourage families and village communities to reflect on the practical consequences of some of their health practices which sometimes lead to new attitudinal change and increased awareness about good health behaviour.

Demonstration is equally important and widely used to try out new health behaviours on practical basis for individual trainees and members of the communities on such matters as, for example, breastfeeding practices, family planning methods, oral re-hydration, simply self medication and protection etc.

Case-study presentations (e.g. the Aro village experiment with Professor Lambo; the Malufausi experiment etc), role playing (e.g. in the Film That Our Children May Not Die by Lagos); demonstrations with songs, proverbs etc. natively coloured to have major impact and appeal have been all used heavily in Nigeria for the training of primary health workers in different rural communities and the advantages and merits of othese techniques and methods for training are considerable; for example:

1. they provide the trainees an opportunity to learn people's reaction to some health habits, to understand the local people more, to prepare them for their future work etc.
2. they provide them the opportunity to learn essential communication skills and how to work with a team individually and to work as a team collectively
3. they help primary health workers to learn and understand customs and beliefs of the village people more
4. they bring the trainees closer to the communities which prevent both alienation and isolation.

EVALUATION

The Nigerian primary health authorities have not developed a uniform method of evaluating the quality of training received by primary health workers in their various rural communities, but some genuine efforts are being made by state governments to implement their own respective primary health workers' training policies to better advantage, with overall aim of improving the efficiency of (PHWs) and other health auxiliaries as well as making primary health care more effective.

Evaluation is not necessarily exercised by primary health care officials and supervisors alone, but in many communities, the village people themselves or the village health committees take part also. There are always many opportunities during learning/teaching activities in some rural communities of Nigeria for the (PHC) management to ask for an evaluation to be done which is primarily concerned with the primary health workers's ability to do certain practical things or accomplish certain practical tasks as required by his or her supervisor or communities.

Some types of evaluation are commonly used in the rural communities where training is undertaken and evaluation is best achieved while the primary health worker is doing practical work. The main types of evaluation that are widely used include:

- i) observation: the (PHWs) teacher or supervisor or indeed the community members observe (PHW) doing practical work and asking him or her questions during e.e. home visiting etc; and
- ii) group discussion .. during which the teacher or supervisor observes (PHW's) participation ability, especially his or her contribution to discussion.

This observatory evaluation is not just restricted to looking, but also extended to finding out, for example, such information as

- i) achievements and failures of (PHWs) in primary health activities
- ii) how did the primary health worker try to find out about a problem?
- iii) what action did he or she take?
- iv) did he or she use the right attitude to teach a villager how to care for his health etc.

However, many primary health workers undergoing training in Nigeria are sometimes questioned by their teachers or supervisors. Questioning is important and used to evaluate what the (PHW) knows. In certain cases, the (PHW) is questioned by his or her teacher or supervisor at the end of the learning experience in the rural community about variety of health

problems, and ways to go about solving them. The results of evaluation of primary health workers training in many primary health activities in Nigeria tend to show that the common problem with training evaluation of (PHWs) is that the outcome of these training evaluations in majority of cases are not very conclusive, for example, it has been observed that many of trainee primary health workers know but cannot do some of the basic instructions taught, while others do not know but can do these basic practical instructions as they are taught.

There are, however, a few of them that tend to know and can do what their teachers and supervisors have taught them. But in general terms, the primary health care management in Nigeria are still striving to strike a balance between learning objectives for these primary health workers and systematic evaluation of their training. Learning objectives are aimed at producing a (PHW) who knows the important thing about the tasks he is doing and can do that particular task in primary health care efficiently. Therefore when results of evaluation are obtained, it may be possible to compare them with the learning objectives so that the management can see if the (PHW) has learned all that he or she should have learned. If he or she has not learned as expected, the management can correct the weak points with the view of increasing overall work efficiency. However, the technical details about learning objectives and evaluation as they affect the Nigerian (PHWs) in training have not been given full attention in Nigeria; for an efficient training evaluation of the Nigerian primary health workers in training these two are basic essentials required for improving quality of training all the Nigerian PHWs.

SUPERVISION

The Nigerian primary health workers are trained to be efficient in their duties and to follow the instructions given to them by their supervisors. Sometimes supervision is not restricted to supervisors only but also undertaken by some village health committees either separately or in collaboration with several supervisors that have been appointed officially by the Nigerian health authorities. Supervision of primary health workers has been inefficient in some rural communities due to some cultural and traditional constraints following village people's negative response to basic health services available. But more than these constraints, supervision of Nigerian primary health workers has not sufficiently been based upon two-way process; for example:

- i) as a learning situation and;
- ii) as a teaching situation.

Both of these are very important in supervisory duties particularly as morale of primary health workers depends so much upon the relationship established between them and their supervisors and support given by their supervisors in their learning process. Adequate supervision, however, has been achieved in some communities where supervision is very much on the job oriented and where supervisors themselves lived in the same village as the primary health workers for a period of time giving practical help and instructions; checking on what has been done or achieved and what is left to be done; promoting good relationships between primary health workers and the village people. In some rural communities, supervision of new

primary health workers is undertaken by the older ones with some accumulated experience in basic health care but they are expected to call upon the officially appointed supervisors or health centre staff for help in cases where they have special difficulties or are incapable of dealing with. The community members in several villages also have some responsibilities for disciplinary actions against the uncompromising, irresponsible and uninterested primary health worker, for example, he or she could be dismissed or suspended by the village health committees or other representatives if he or she misbehaved in course of his or her primary health care duties.

The supervisors that are appointed by the Nigerian health authorities have the tasks of supervising some aspects of quality of care; use of drugs; the content of health education, the accuracy of records; the on-going education programme of primary health workers etc. The majority of health centres in Nigeria also carry out some supervisory duties being themselves the ones in closest relation with primary health workers but it is observed that most of these health centres and their staff have not been trained for this supervisory role and hence do not do it properly. Other health centre staff simply do not accept it as part of their duties. But increasingly, it is being realised by majority of health centres that they really have some contribution to make in the supervision of primary health workers especially in the process of referrals, exchange of information and feedback between the primary health workers and health centre staff. Health centres now undertake supervision of primary health workers in some Nigerian rural communities specifically to determine how close they are to achieving those tasks they have been given in their communities, for example, assessment of the health needs of communities, feasibility of

introducing new health behaviour or change; records of basic health care statistics; mass immunization campaign; health education programmes etc.

Many local health authorities and their communities in Nigeria have established village health committees in their own areas, as a starting point for efficient supervision of primary health workers and also to remain essentially the bridge between local health authorities and their local communities in community health matters. In addition to the main responsibilities of these village health committees (selecting, supervising disciplining, of primary health workers), they for example:

1. assist in matters of referrals, assessment of quality and quantity of health facilities available to community etc
2. maintain good working relationship between health centre staff, primary health workers and communities
3. organize meetings with the village people to discuss ways of improving public health and to obtain their co-operation and commitment to them.
4. supervise and co-ordinate activities directed towards improving sanitation and hygiene: refuse collection and disposal: protection of wells and other drinking water sources; encouraging regular use of latrines etc
5. examine reports about work of primary health workers
6. mobilise resources locally to support primary health care development
7. ensure inter-sectoral co-ordination of health activities with, for example, other sectors - education, agriculture etc.

SALARY AND REMUNERATION

The local health authorities or local governments in majority of the states are the paymasters responsible for primary health workers salaries and remunerations and usually salaries are paid mostly in Naira and Kobo (cash). The rural communities do not share the financial responsibilities for paying salaries of primary health workers mainly because these communities do not have employment opportunities for village people and this restricts or limits wage earnings. Absolute poverty in these communities does not only exclude the communities from contributing money for the salaries of the primary health workers but also affects basic health care provision, basic health care utilisation etc (in terms of utilisation of care, for example, this is quite low because the village people themselves are too poor to pay for health care costs). However, these communities are able to provide land, material resources for use by primary health workers and for primary health activities (agricultural and food plantations, fruits and vegetable in the gardens, huts for accommodation, public latrines etc). In this way, the communities are able to contribute in kind substantially to motivate and encourage primary health workers.

It is observed that the salaries and remunerations of primary health workers vary from state to state. In general, the primary workers in the northern states are paid far greater than their counterparts in the southern states. In the north primary health work tends to be accepted as a promising new career for primary health workers with some great opportunities for advancement to more responsible positions. In the north also, the political will to pay primary health workers a decent wage or

salary is very much alive. In contrast, the southern states lack financial resources both to pay basic health workers as a whole and government full support to develop primary health care is far from becoming a reality. However, this picture is beginning to change as the public in the south are beginning to read and understand the main objectives of primary health care and the very necessity of improving public health. But this change is both slow and patchy due to cultural, financial, policy (PHC) constraints. Beyond these, the usefulness of the work of the primary health workers themselves are not yet widely recognised and appreciated. This makes PHC as a career uninteresting for primary health workers and their apathy is quickly turned into high staff turnover, resignation, etc of the working primary health workers. Furthermore, community involvement in primary health care activities and also in the payment of salaries and remunerations of health workers in the rural communities are weakened by local disputes surrounding selection and training of these workers: there is widespread claim in the villages that majority of primary health workers come from the families of the key officials in the state or local government administration and have used their positions to influence selection and training of these primary health workers even when they do not meet selection criteria as endorsed by their local communities. However this trend is fast disappearing as the military regime is expressing strong views and showing considerable interests in primary health work, primary health workers and their salaries and remuneration at all levels of government - federal, state and local government.

PROBLEMS

The Nigerian primary health workers are beginning to express opinions about insurmountable tasks and problems that face them in their primary health care activities. In the main, they are very concerned about practical problems that exist or arise in the course of their work for example; the problems relating:

- i) obstacles against active community involvement in PHC
- ii) diversity of interests and priorities in many Nigerian rural communities, states etc
- iii) social divisions and sectionalising amongst and within Nigerian various cultural groups (Ibo, Yoruba, Hansa etc)
- iv) resistance of PHC administration to decentralise planning, decision-making etc, and delegate some activities to local health authorities management
- v) failure or lack of reorientation of health workers in PHC
- vi) inadequate budgeting for PHC programmes
- vii) lack of local organisations and women and village health committees in many rural communities.

D. PHC GENERAL DEVELOPMENT PROBLEMS IN NIGERIA

1.1 THE SHORTCOMINGS OBSERVED IN NBHSS MANAGEMENT

According to (Africa Health, 1979) recession in the Nigerian economy has affected the planned development of health service and as a result some major shortcomings in the implementation of NBHSS have been observed.

Amongst others, the main shortcomings include the following: the population coverage was still below 40 per cent in 1981, far from reaching the target; lack of funds retarded PHC progress, regional and zonal inequalities still pose big problems; health care facilities are inadequate in majority of the villages; the villagers resented PHC which was seen as incomprehensible organisational change; the grassroots have increasingly become passive beneficiaries of programmes directed from above rather than being agents of their own development, (bottom-up planning and development strategy is therefore needed to make PHC successful in our villages); lack of community involvement in the planning and management of PHC activities; facts about PHC as new concept and an organisational change have never been properly explained to and discussed with the rural community members - for example, the need for team-building and full co-operation at all levels between the community, the PHC management and the health workers. The need for team work has been explained in some of the Reports by (a Sub-Committee of the Standing Medical Advisory Committee, 1977), (Bryant, 1969), (Bloomfield, and Follis, 1974) and (Flahault, 1976). Also there has not been discussions with local communities to explain procedures for settling disputes and resolution of conflicts as part of management functions; a local but efficient means of

spreading information regarding PHC activities, especially where local press/media is not existing; lessening fears of the villagers by reassuring them of the importance and benefits to be gained from PHC approach; broader awareness of health education and its usefulness.

Other shortcomings of the NBHSS include lack of local organisations and appropriate local government structures to organise very effective village health committees; there is no effective mechanism for linking the activities of the health sector with those of other health-related sectors (education, agriculture etc); there is yet no agreement as to how much financial contributions would come from the Federal State of Local governments as fair quota in fund raising; there is not yet evaluation mechanism with adaptable indicators of PHC effectiveness or ineffectiveness; there is no provision for improving the control and monitoring of drug importation and also putting into better use of the list of 200 essential drugs produced by WHO (WHO Action Programme on essential drugs, 1981); resistance of the Central Administration to decentralisation; reluctance of medical professional - especially the young graduating doctors to practise in the village(s): Howe and Warren (1977) believe that the alternative way to approach the Health Care problem in rural areas is to accept the possibility that physicians may not choose to stay in rural practice, and to organise primary health services so that an institution, rather than the physician - personality, becomes the focus of patients' relationships in the health sector. Many other shortcomings are related to problems of mismanagement, a deficiency of funds and a rash of fraud as discussed under Health Administration in Nigeria (Appendix 2).

There are many problems associated with drug production, quality and quantity control, all leading to drug abuse, misuse, wrong self medication. Inefficient drug-inspectorate and regulatory control as well as shortage of drugs reduce efficiency of health centres, clinics etc. It is observed that due to lack of drugs in several Nigerian communities that the situation encourages quacks to obtain all types of drugs wrongly. There has not been an effective statutory requirement of provisions to deal with this worrying trend and no severe punishments have been imposed on offenders. The quacks indulge in therapeutic malpractices which endanger life, criminal misuse of drugs, improper storage which makes these drugs useless long before the expiry dates. The inspectorate unit of the Pharmaceutical Division of the Federal State Ministries of Health lack appropriate powers to arrest and deal with persons who infringe drug regulations. The present procedures for dealing with people who contravene drug regulations in the country are imprecise, cumbersome and penalties for culprits too lenient. This leniency has in turn, encouraged even those who smuggle into the country certain dangerous substances such as cannabis, marijuana, etc to remain undictated or unpunished or both.

Although primary health care was proclaimed a new-wave in health delivery in Nigeria and expected to be funded by the Federal government it is observed that the government is lacking the political-will to promote and finance primary health care activities and programmes. The consequence of this, is that primary health care concept in Nigeria as a whole is almost nearing a disaster as states spent their sub-ventions on running their hospitals. Today the whole concept of (PHC) is in disarray.

No one wants a mere health clinic, rather, every village wants a health centre to which the next door village will refer its patients, not the other way around. These local or village disputes are not restricted to one section of Nigerian rural communities alone but are growing in magnitude across the whole country. Added to this confusion, there is another dimension of the problem: even if people make up their minds on who should have what, there is quite simply not enough funds to cope with the new health revolution or primary health care.

1.2 SOCIO ECONOMIC FACTORS

Observing that disease, illiteracy and poverty are closely associated with poor health in many Nigerian and Agrarian rural communities, it is not too difficult to perceive these as social-economic and health problems which retard (PHC) development in Nigeria. Therefore the quality and standard of health in these rural communities can easily be determined by poverty, unemployment and bad housing conditions which prevail in them, and the village people are specially vulnerable to ill-health and environment especially likely to generate it. Poor health is just one of the many social and economic ills which are especially concentrated in Nigerian rural communities and to many village people, it may only appear important at times of serious illness or death. It has long been observed (Luft 1978) that poor health and low educational attainments restrict employment chances. Low income as a result will often mean bad housing and this may not only damage health but also determine similar future for one's children. With less employment, educational and housing opportunities in many of Nigerian rural communities, poverty and poor-health have co-existed and this in turn reflects Nigeria's high morbidity and mortality

rates as well as long-term unemployment, while life expectancy is still very low (about 45 on average). In the rural areas poverty, malnutrition, poor hygiene and sanitation contribute to high infant and child mortality. Lack of safe water represents a major cause of ill-health in many of our villages, where sometimes water supplies are also uncertain. Many of the village women and children often have to cross long distances to secure their minimum requirements of water for family and for domestic purposes. The larger proportion of the water is mostly polluted due to bad sanitation and this gives rise to deaths from diarrhoea and water-washed diseases.

The strategy for improving health in Nigeria requires efforts far beyond medical care, it must be closely linked with food and nutrition improvement, with employment opportunities, income distribution and so on. In 1978, the (WHO) conference in Alma-Ata, for example, set a target for government and the world community, to attain for all people by the year 2000 a level of health that will permit them to lead a socially and economically productive life; with (PHC) being globally suggested as the key to attaining the target. But Nigeria's pursuance of this global strategy tends to lack both political will and joint efforts by health sector and health-related sectors (education, agriculture, transport etc). Furthermore, the opportunities to obtain and produce basic medical drugs that are most essential are non-existent. Both the resources and political determination needed to reform the Nigerian orthodox medical systems to ensure co-operative community activities for (PHC) development are lacking. Poverty and poor health : the nature of poverty in several Nigerian rural communities shows homes constructed of impermanent materials (thatched houses), homes without piped water and sanitation; health services are either totally absent or thinly spread and only rarely

within walking distance. Permanent insecurity is the condition of the poor in a Nigerian rural village and this is further made worse as there is no public systems of social security in the event of unemployment, sickness or death, of the wage-earner.

It is increasingly becoming feared that the majority of African communities are being confronted with a different kind of poverty . flooding, drought, famine, disease and poverty of knowledge, all severely affecting people's lives and the livestock - a trend which in the Western world can only be termed absolute poverty. The nigerian communities although not yet severely affected by these natural and man-made disasters (wars, militarilisation, famine, political upheavals, bribery and corruption etc.), they are however, not completely far away from them, at least from the point of current economic hardships and socio-economic problems relating illiteracy, high birth rate, unemployment, low income, bad housing, malnutrition (etc). The Federal government in June this year (West Africa 1975) donated over 5,000 tonnes of maize to the drought affected areas of Kano State for distribution to the victims of the drought, following the devastating low rainfall and extreme low humidity figures in the prolonged dry season with the dusty harmattan winds blowing southwards from the Sahara desert, which destroy crops, grazing lands, and leave both animals and cash grains dying. The distribution of grains by the central government to the drought affected areas of the Kano State is held to be short term measures of tackling drought problems in the region while a meaningful and concerted effort for a permanent solution is still being researched for (West Africa 17 June 1985). In the southern region as a result of oil-spillage, substantial disappearance of animals and fish is continuing in parts of Cross River and Rivers States with the crops and farmlands being impoverished as a result of the activities of oil-drilling companies.

Disease and Nutrition. Diseases of under-nutrition in Nigeria are mainly caused by either too little food, defective digestion or absorption or any combination of these. The effect of under-nutrition in Nigeria is more acute in children which sometimes results in stunted growth, underweight, (Kwashiorkor) malnutrition and death. Under-nutritional diseases of Nigeria are also caused by lack of care of children on the part of some parents. Starvation and vitamin deficiency promotes such diseases like scurvy, rickets, osteomalacia. Ignorance also represents lack of progress to combat or prevent disease associated with vitamins C and D deficiencies, while balanced diets rarely constitute daily meals : a balanced diet should at least contain the right amount of carbohydrates to provide energy for the body, it should contain materials for body building - proteins; it should provide heat for the body-fat; it should contain small elements without which the body will not function properly - vitamins and minerals, it should be free from contamination and disease. Apart from undernutritional diseases in Nigerian rural communities, there are additional food problems which work against (PHC) development and these are beliefs in certain food taboos, for example, some Nigerian pregnant mothers do not eat eggs because these are believed to make babies dumb or bald headed; fish is believed to cause intestinal worms and poor growth in children or expectant mothers; pregnant women drinking milk may suffer from congestion of the breast and breast inflammation, rich foods, bread, butter, banana - all cause large babies and therefore mothers eating meat will suffer from excessive bleeding after the baby is delivered and their healing process delayed. Mothers who eat peppers will have babies that cry a lot and those who eat garden eggs and bitter tomatoes will have children that suffer from ring worms. Therefore what is needed is to mount an effective nutrition

education campaign which is designated to change these beliefs and attitudes of village Nigerians to improve the quality of their life and that of their babies.

Food shortages : Most of the rural communities, especially in the far north, fall victims to hunger and food shortages because of insufficient attention being paid to irrigation, agricultural storage, increase use of fertilizers and other inputs, and fishery development. Agrarian reform though very important in Nigeria (eg the Green Revolution National Food Production Campaign) has not been effectively and vigorously implemented and pursued to increase food production and to put higher incomes into the hands of the poor. Added to this drawback, the governments food aids have not been increased and linked to employment promotion and agricultural programmes and projects to overcome hunger and food shortages. Hunger and food problems, it seems, would not completely be wiped out in Nigeria unless there are effective ways of ensuring a broader package of policy improvements aimed at expanding social services to reach the poor, agrarian reform increased development expenditure in the rural areas, stimulation of small-scale enterprises and a better - administration system. These measures can lead to the country's self-sufficiency in food production as well as satisfying some elementary needs of people, but there are serious doubts whether these measures would ever be seriously considered, at least as part of the process of (PHC) development.

Agrarian revolutions appears to precede industrial revolution, at least, this was the experience of Britain which colonised Nigeria up to 1960. In contrast, the pattern of development in Nigeria has been to have industrial growth alongside agricultural growth. The tendency is that industry in

Nigeria draws away labour from rural communities since traditional agriculture involves the drudgery of tilling the soil with antiquated tools while industry has advanced or is advancing to a computer era. The Nigerian agriculture can be mechanised if sufficient capital and technology are put into it, and there are good reasons for this to be done : a lot is expected from the Nigerian agricultural sector - producing enough food as a challenge to the rising population (with the forecast predicting 150 million population in 1990s); providing employment opportunities; higher per capita income, foreign exchange earnings; self-reliance in food production; provision of industrial raw materials; production of livestock and fish to meet domestic needs and create a surplus for export; evolution of appropriate institutional and administrative apparatus to facilitate rapid development of the country's agricultural potentials.

Water and Soil Management : The most fundamental difficulty in the Nigerian agricultural system is inefficient methods of control and management of water resources, especially in the northern states of the country, where water availability is most difficult. Equally the problems of the south is that crops in the more humid zones are damaged by severe flooding during the heavy rainy seasons. Furthermore the crop yields in these humid southern states are limited by high cloudiness, by disease, by root-zone saturation and by losses of soil nutrients through serious leaching.

In the north, the unpredictable rainfall makes agricultural planning difficult even in the best circumstances, but once water is available all the year round, the farmers are protected from the vagaries of the climate, which is the most important single measure to encourage them to adopt improved

farming techniques. However, in the north much of the farming is done by irrigation methods within the semi-arid desert where evapotranspiration is exceedingly high and rainfall very low. An irrigation system with proper drainage gives greater yields, a more flexible choice of crops and more intensive farming. It also contributes to hydro-power. In Nigeria, some major irrigation schemes have been achieved in the river basins of Nigeria, Lake Chad, Kainji Dam (etc), all in the northern provinces, while at the same time small irrigation projects have been introduced at rural community level, following the continuing research to improve inputs of seed varieties and fertilizers and a better balance between production methods and the environment. Further research is necessary to learn the best measure to maintain soil fertility, to control weeds, diseases and pests, and to prevent soil erosion in the whole country in order to produce sufficient food for the population. By studying the actual environment in which the Nigerian farmers work, researchers may be able to give relevant advice to contiguous rural communities, for example, about crops in relation to local climate and soil type - the agro-economic specific zones, which can be done by exerting considerable pressure on local governments to deal with and remove the institutional barriers and issues that otherwise frustrate agricultural development in Nigeria, including agrarian reform. The governments should also find ways to transfer workers in the slack season to improving the land with such supporting activities such as building, fencing, drainage or small irrigation constructions. Deforestation in Nigeria has major implications for both food and energy requirements and for (PHC) drug development. The rate with which Nigerian trees and forests are disappearing is alarming since ordinary people and most homes rely on firewood as the main source of energy. There are also some commercial reasons while the disappearance of trees is continuing : many

traditional doctors, traditional birth attendants and modern pharmaceutical industries in Nigeria produce drugs from herbs, barks, roots and woods from different plant species in the country. Added to this, Nigeria is African commercial centre of what is nationally known as 'chewing stick' believed to be a very good toothbrush and believed also to keep one's teeth strong and healthy. This unrestrained commercial exploitation and increased population in Nigeria have led to the soaring wood prices and more and more physical energy is expended to satisfy the basic fuel and energy needs especially in the rural areas, and this has meant that animal manures are diverted from food production to cooking and the treeless landscape extends further in the south with disastrous effect to ecology. The firewood crisis in many parts of Nigeria is intimately linked to food problems in at least two main ways :

1. the destruction of the forests accelerates the erosion of the soil, increasing severe flooding and creeping deserts and thereby reducing soil fertility.
2. the diversion of manure for use as fuel leads to a loss of agricultural nutrients, damaging the soil structure by failing to return manure to the fields.

The result is a circular trap : as wood scarcity forces Nigerian farmers to burn more during for fuel and to apply less to their fields, the falling food supply will necessitate the clearing of ever larger, every steeper tracts of forests which then intensifies erosion, which in turn reduces soil fertility. Massive erosion has taken its toll in areas of Imo and Anabra States. Desertification is a man-made phenomenon in Nigeria and only human action can halt it.

EDUCATION : Literacy in Nigeria has made varied progress. A small percentage of the population had the opportunities to learn how to read and write while over 80 per cent of the people are still illiterate. Higher education has often expanded too fast in the country for a few people for a small number of better off families. It is the higher education system in Nigeria, as opposed to the elementary education system, which all the time takes a disproportionate share of educational budgets to the disadvantage of the uneducated masses.

This mass illiteracy has serious health implications for many Nigerians, when it comes to learning personal hygiene, introducing and implementing health education schemes, improving sanitation and food nutrition, learning ways of preventing certain infectious or contagious diseases, responding positively to immunization campaigns (etc).

HOUSING : The need for housing is fundamental to effective community and public health care in Nigeria housing needs have not been given sufficient attention, particularly in the rural communities, to improve the quality of life.

Due to lack of housing and employment opportunities in the rural areas, there has always been a rush to big cities of Port Harcourt, Kano, Enugu, Ibadan, Lagos, Jos and the migration from rural communities to these cities in turn creates a lot of human misery in terms of overcrowding situation, unemployment, strains on family budgets, poor sanitation, lack of safe play facilities, lack of transport (and this seriously affects people's diet and nutrition), crimes of assault, offences against public decency and morality, burglary and theft, homelessness, drug abuse, alcohol addiction and so on.

The housing problem in some rural communities in Nigeria is acute and affects the poor to whom there is little or no government assistance whether in the form of rehousing schemes designed to improve housing standards, to supply minimal essential housing services through security of tenure in relation to local land laws or to take climatic and environmental factors into consideration, or by giving housing subsidies in the form of cheap rented accommodation. The Federal Government's direct housing construction programmes have not been particularly favourable to or effective in the rural communities. The first is the direct construction scheme which is under the supervision of the federal ministry of Housing and Environment : the programme which is aimed at constructing 2,000 housing units annually in each of the 19 states, with the bulk of these units going to the low income public. The second programme is aimed at housing both middle and high income earners and executed by the Federal Housing Authority. The third programme is states urban housing development scheme consisting of social services, including schools and hospitals, a general up-grading of slums and the provision of sites and services with the Federal Mortgage Bank of Nigeria financing and co-ordinating the housing schemes.

The problem with the Federal Government's construction programmes in the Fourth National Plan period is that their implementation was both slow and uncompleted due to cash shortages. But more than this, they did not address themselves to the real housing needs in the rural communities and allocating sufficient funds for reconstruction and improvement of houses in very poor state not just in the villages but also in several shanty towns where housing problems are increasing steadily and housing conditions very

unsatisfactory - poor ventilation, lack of home facilities, poor sanitation, rising damp and so on.

There is growing evidence that health problems may be due to some socio-economic factors. Luft (1978) shows that there are three major groupings of causes of various health problems : genetics; specific external agents; and psycho-social stresses. He claims that diseases such as haemophilia conditions have very clear genetic causes; that specific agents such as bacteria and viruses have long been identified as the causes of certain conditions such as infectious disease and that psychosocial factors have been recognised for example by (Cassel 1974) and (Mechanic 1968) to have some influence on health. Many socio-economic factors are associated with health problems in many other ways, for example : low income people may not have enough money to buy the food necessary for a nutritious diet that helps prevent disease. But equally, it may be possible that low income people may choose an inappropriate mix of foods that does not provide the proper nutrition even though they could afford a proper diet. In the first low income group, income supplements would lead to better diets and health; but in the second group, diets would not change. It will be necessary therefore to determine what caused the choice of poor diet (e.g. ignorance, illiteracy etc.) and perhaps, try to alter the behaviour. In Nigeria socio-economic factors that cause health problems are also associated with, for example, occupational and domestic hazards : farm work; machet and knife cuts; insect and zoological bites; infectious from dogs (rabies), cats cows, pigs; hazards from fetching water, firewood; health problems due to excessive kitchen smoke which irritate eye and cause infections; health problems connected with cigarette smoking, alcohol consumption; use of certain hard drug (cannibis, cocaine etc), atmosphere air pollution etc.

Furthermore a greater number of impairments or disabilities in Nigeria are associated with socio-economic factors, especially health problems and impairments caused by undernutrition and lack of vital vitamins or others caused by certain micro-organisms resulting in river blindness.

In many situations, the health problems caused by socio-economic factors by themselves led to loss of income, or affect family roles and family composition which in turn cause worries - a vicious circle short of socio-economic health problems.

There are equally other socio-economic problems that prevail in Nigeria which hinder (PHC) development : costs of imported foods are continuing to rise beyond expectation. The immediate impact of this, is that poor people cannot afford to buy the food that is necessary to support and improve life since the domestic price of foods is high and in some cases unequally distributed between urban and rural areas.

There are also aspects of socio-economic problems in Nigeria which need to be paid attention to : the various traditional community means of livelihood are in decline. The traditional crafts like potting and iron/blacksmithing which had been once a major source of income to many villages are rapidly disappearing; and techniques for manufacturing cost aluminium pots, earthenware vessels, cast iron, plastic and machine-made aluminum pots and containers, locally made hoes, new crafts such as sandal-making from old car tyres have all been abandoned as migration to Nigerian urban cities in search of more paying jobs increases. Many village bars and shops no longer exist, soaps and medicines made from local plants, shrubs, trees to

fill the gap left by the increasing shortage of drugs are no more available as they used to be. Hunting and trapping of animals and setting bush-fires to round animals up to obtain meat and protein is becoming a thing of the past. Honey collection, wine-tapping and locally brewed beers are no longer seen as viable ways of making a living in the rural communities. Many people tend to blame the pace of industrialisation and the then oil-boom in Nigeria for much of these destructive changes that have taken place in almost all the Nigerian' villages, a kind of transformation that was very much reinforced by people's pursuit of naira (money) which is always in greater circulation in cities more than it is in the rural communities.

1.3 TRANSPORT AND COMMUNICATION

The Federal government had a major policy in transport and communication and the management and maintenance of the existing facilities during the Fourth National Development Plan, but the transport systems in the rural areas are very poor and have not been considered as very necessary to the revival of rural economy. The few roads and rail lines that exist are left in very bad state which does not guarantee efficiency, safety and reliability of the system. It is in the rural areas that construction and expansion of infrastructure facilities of the various modes of transport are particularly relevant since the problems of imbalance in Government investment as between the rural and urban road services and transport improvement affect both the economy and the life of people in the villages where transportation has remained inadequate and unreliable, whilst many of the big cities are adequately provided with cheap, economical and more reliable service.

Transport and communication problems hinder (PHC) development in Nigeria in several important ways : many Nigerian rural communities are not only landlocked but are also divided by mountains and hills which isolate their communities from the rest of Nigerian communities, and which restricts efforts to promote mobile health services. It has become unsuccessful to extend transport and communication systems to reach isolated areas and to promote trade and link farming and other activities to the markets; to reach remote health centres, clinics, dispensaries, maternity homes, hospitals. The inadequacy of the transport systems in the rural areas is not only due to restriction of government funds and investments in the village, but also due to difficult terrain and bad weather conditions which affect and damage the existing roads beyond repair in several parts of Nigerian countryside.

1.4 POPULATION GROWTH

Population growth in Nigeria represents a serious socio-economic problem; and a major threat to urban, rural and (PHC) development in Nigeria. The population of Nigeria will, at least, increase by between 35 to 50 million by the year 2000 (Nigeria Today, 1977) bringing the overall population figure to about 150 million.

As Nigeria's population continues to grow, there is a continuous exodus of people from countryside to Nigerian cities in search of jobs, improved social services, better standard of living and so on. The concentration of indigenous migrants in Nigerian cities has many social and economic consequences : accommodation shortages, poverty, crime waves, undernutrition, social deprivation, unemployment and so on. Furthermore,

the quality of life is affected, especially for the people who are poor and live in the slum sub-urban areas, where medical services are scantily provided and the quality and standard of care very low. The poor may not have full access to health care when they fall ill because they cannot afford to pay for health care and treatment.

The overpopulation of Nigerian cities due to influx of people from villages is becoming a political embarrassment to Nigerian governments because no government is seriously thinking of investing more money in the rural communities so that the pressure on the available resources, social services, available food, health services necessary to support life in these major cities can be reduced, while at the same time the quality of life in the rural communities is increased through community and social services' development programmes, which can also create job opportunities for the village people. Meagre and unstable economy, poor health, poverty, food shortages, family tension etc have always been associated with overpopulation problems in several countries where their governments have done and are doing everything to combat the problems by various means, for example, India attempted introducing sterilization system to reduce its birth rate which received the approval of Indian government and endorsed by (Mrs Gandhi) the late Indian Prime Minister, but the system failed because it was not acceptable to the majority of Indian people, especially from cultural and religious grounds.

China also attempted discouraging large families in China by levying and imposing fines and penalties. But this method only flourished well in some parts of China but failed in others. The Nigerian population problem is accute, due to the continuing high birth rate (and falling death rate

associated with improved living conditions and medical facilities in some states). The Nigerian national population control policy has not critically examined the complex relationships between different measures of population control systems, their efficacy and their effect on socio-economic development. Socio-economic development for example may be more effective through a national transition from high to low birth rate if families will accept to limit family size and if the governments accept to provide and expand family planning facilities, and seek solution to those social-psychological factors that tend to generate disapproval of family planning and limit the actual use of contraception especially amongst the village women in Nigeria : lack of knowledge on the variety of contraceptive methods; insufficient husband-wife communication; desire for a large family; lack of informal communication or family planning; lack of concern for pregnancy and its implications; the importance of having a son; religious and moral beliefs; lack of awareness about the demographic problem: lack of awareness about ethical problems surrounding abortion; rumours and beliefs about contraceptive methods. As Soto and his team (1978) maintained, many social-psychological factors can be a real barrier to a successful family planning strategy as had been the case in Guatemala, for example.

1.5 HEALTH SERVICE

There are a number of health problems that are common in Nigeria, PHC services especially in the rural communities, and these may include shortage of health manpower; uneven distribution of health facilities; lack of preventive health care; mismanagement of health institutions; inadequate health statistics and vital records of births deaths etc. These

health problems in Nigeria are very similar to the health problems which the (WHO 1973) enumerated and confirmed to be most common in developing countries.

Bassier (1973) identified health service problems in Nigeria as shortage of doctors, inadequate laboratory facilities, poor surgical facilities, shortage of drugs, poor feeding procedures, environmental infections, bribery from Porter to Consultant and general lack of basic health services. It has therefore become quite clear that some of the health problems in Nigeria are themselves exacerbated by individual, government actions and inefficiency in other health related sectors education, agriculture etc), and above all exacerbated by very bad housing conditions, poor sanitation and inadequate transport and communication systems.

Equally distressing are the variances which exist between the federal, state and local government's health statistics records in Nigeria. The federal Ministry of health in its Statistical Annual Report (1975) explained that the discrepancy in the government health statistics was due to unorganised collection of returns at state and local health authority levels - the responsibility of such collections being solely that of the state ministry of health.

The structure and organisation of the Nigerian health services also hinders (PHC) development in several respects : it does not allow national decentralization of (PHC) activities, including decision-making and planning processes. This leaves the federal health system open to rigid bureaucracy, and (PHC) decision-making process subjected to a slow process which brings about inefficiency in the service.

The structure and organisation of the national health system does not also show clear lines of responsibilities for (PHC) development at federal, state and community levels. Because of this, managerial authority, control and delegation of responsibilities at each level of the system are unclear.

The Nigerian Medical Association (NMA) (1966) suggested a central government control of all the health institutions and the decentralization of medical care which promotes private practice establishment. Awolowo (1968) in an official political statement advocated for a free health service system in the country but this was seen by many as an electoral campaign strategy designed to win him votes. Lambo (1977) called for a 'general duty medical education system which minimises the period of medical training in Nigeria and maximises the number of qualified doctors for deployment in rural communities. This is because the Nigerian health system continues to be seriously affected by shortage of doctors. Whilst the target set by WHO for developing countries is a doctor/population ratio of 1 : 10,000, the stock of doctors in Nigeria since 1972 has not significantly increased beyond the ratio of 1 : 22,000. To achieve the (WHO) target in Nigeria, Nigerian medical schools may need more than double the number of doctors they are currently training.

Of most serious concern is also the imbalance in the distribution and deployment of the available doctors among the various population centres in the country. A major reason for this imbalance is that health personnel are attracted to work in teaching hospitals and state general hospitals mainly located in the cities where there are improved social and medical facilities, job opportunities and opportunity for advancement to higher posts by promotion.

This imbalance between the urban and rural deployment of doctors denies a large and preponderant segment of village populations adequate health attention. Staff shortage are not restricted to doctors alone but are also inherent among the sub-professional and para-medical health personnel : medical laboratory technologist and technicians, pharmacists, radiographers, nurses (etc). However, there is justification that with Nigerian's present shortage of doctors and para-medics, for positive consideration to be given to an efficient system which ensures equitable distribution of doctors and health workers in the country specifically designed to improve rural health services and attain efficiency through home visits and referrals from health centres and dispensaries to well staffed and equipped rural hospitals.

Consideration should always be given to any other non-hospital based alternative schemes which may utilise or attract doctors services in the rural communities : more incentives for (PHC) responsibilities in village, subsidised living accommodation, high salaries, promotion prospects etc. This is especially important because the long standing staffing problems in the rural communities are due to the fact that many health workers tend to see rural health service posting as inferior, and the immediate effects of this, are obvious - staff moral tend to be generally low when posted to rural communities and this is followed by rapid staff turnover. The considerable demand for curative services in Nigeria tend to be allocated more resource than to preventive and educational health programmes needed in several Nigerian rural communities to deal with preventable disease such as malaria, gastro-enteritis, cholera, dysentery, tuberculosis, meningitis, tetanus which according to Federal Ministry of Health (1975) still account for high percentages of cases of illness.

Communicable disease : Airborne diseases also account for substantial proportions of deaths in Nigeria with pneumonia, whooping cough, measles, tuberculosis being the most common.

The ability to mount effective national immunization campaign in Nigeria is dependent not just on a satisfactory transport and communications infrastructure but also on the ability of local primary health workers to motivate and organise the dispersed populations so that coverage is comprehensively achieved.

Real success to combat communicable diseases in Nigerian rural communities may be achieved especially by accomplishing certain tasks (e.g.) detection of infectious diseases : cholera, typhoid, malaria, polio etc; recording and reporting of births, deaths and marriages; reporting tuberculosis or persistent cough; early detection of leprosy cases; refuse disposal and sanitation improvement; family planning and identification of variety of safe contraceptive devices; improving health education through home visits, regular health checks etc. Nutritional diseases are causing some severe health problems, especially in the drought-stricken areas of the north.

Undernutrition, especially amongst infants and young children is a major cause of disease and death (Bikita 1973), a view which is strongly shared by many writers : Axton (1977) stressed that protein Energy-malnutrition, for example, was the second most common reason for admission to children's ward in Harere Hospital and the leading cause of death. Axton's claim had been supported by other findings in Zimbabwe, for example, those by Riley (1975), stoughton (1975), Knecht-Kaiser (1977) and Clark (1977).

In Nigeria, however, malnutrition tends to be confined to the arid-zones of the north (closer to Sahara desert) where frequently there are prolonged droughts and scanty rainfall, which quickly imposes famine on many families.

Malnutritional problems are also caused by poverty of Knowledge as many Nigerian mothers do not have the basic health education in nutrition to improve their diets and those of their babies, and sometimes there are other dietary constraints connected with cultural and religious beliefs which prevent families to adopt healthy food habits.

1.6 HEALTH FACILITIES

The uneven distribution of health facilities and institutions in Nigeria poses real problem for health improvement of a large number of people in the rural communities. The over-concentration of government finances and resources on many Nigerian general and teaching hospitals (which are themselves situated in the big cities), account for the preponderant majority of available curative facilities. The high expenditures on curative medicine (instead of medicine which is both preventive and curative orientated) leaves the Nigerian rural health services with little or no prospects, as little or no resources have always been allocated to it, and this seriously restricts (PHC) development in the rural areas. The low levels of health facilities in these areas make basic health care quite inaccessible to a greater majority of people, and also widens the gap between the urban and rural areas; curative and preventive care, the rich and the poor. In these circumstances, most rural people in Nigeria still

have no medical services within effective reach of their homes. Also, because a health education system is not developed within a rural-setting in Nigeria, in addition to lack of health facilities and resources, most of the people do not know how to make the most effective use of either preventive or curative medical services, even when these are available.

Another implication of not developing (PHC) in rural communities, to match at least, a reasonable amount of resources being allocated to the general and teaching hospitals, is that the health workers continue to be separated, isolated or uninterested in primary health care services. Again the result of this becomes obvious as most of the health workers do not use the most effective methods of preventing illness and death because :

- i) they have not been trained or retrained to do so; and
- ii) they are not effectively supervised, encouraged and oriented to practical health work in the rural communities, by using the most appropriate health facilities necessary to promote and develop (PHC) in our rural communities.

1.7 CO-ORDINATION

The population composition and disease patterns in several Nigerian rural communities reflect the widespread underdevelopment in these communities.

Qualitative improvement in health will necessarily be the result of thorough going economic and political changes in Nigeria which will ensure

the ending of the process of underdevelopment in the rural areas. As WHO (1978) stressed, 'Health cannot be attained by the health sector alone but also by the other health related sectors also. The Nigerian (PHC) development requires combined strategies aimed at improving health standards through socio-economic development, anti-poverty measures, adequate food production, sanitation and water improvement, adequate housing, environmental protection and so on, as these may also contribute to health and have the same goal of human development. Primary health care as an integral part of the Nigerian health system, will of necessity rest on proper co-ordination of activities at all levels and between health and other health related sectors.

However, it is not yet visible how the problem of co-ordination of activities in Nigeria can be achieved with (PHC) development still on course to succeed nationally, void of sectoral interests which undermine a unified effort to achieve a common goal and objective.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 AIM

The aim of this chapter is to show how the research hypothesis is formulated and to examine the various data-collection methods and the subsequent choice of the most appropriate techniques for the study.

2.1.1 The Formulation of the Research Hypothesis

The study is based on a formulated hypothesis "Primary Health Care can be effective if and only if the Health Care Delivery system matches the attitudes and expectations of the community".

The main task of the study in this hypothesis is therefore to measure attitudes and expectations of the community; define or describe health care delivery system; decide if matching takes place or not between A and B and C as illustrated in Fig. 4 below; and consequently to assess if the PHC is effective or ineffective as shown in chapter five.

Specifically, measures of PHC effectiveness are expressed in terms of the interests of the patients; the village people; the health workers, and PHC management.

In order to answer some of the above questions for the research study, a variety of research techniques and methods have been used. These include

interviews; questionnaires; check-lists; personal observation of events in the rural communities of study etc.

2.2 DESCRIPTION OF TERMS USED IN HYPOTHESIS

2.2.1 How to Describe or Define Health Care Delivery System in the Rural Areas

A good health care delivery system may be characterised by the following:

Availability of Services:

1. Provision of health facilities and other health resources which satisfy health needs of the people.
2. Efficient use of available resources:
Ratio between the population of the village-community and the health facilities and personnel assigned to it:
 - . Population per health centre, dispensary
 - . Population per doctor
 - . Population per traditional birth attendant

Accessibility:

(i) Physical Accessibility:

1. Probable geographical distribution of patients.
2. Measurable distances between patients' homes and clinics: 5-10 miles.

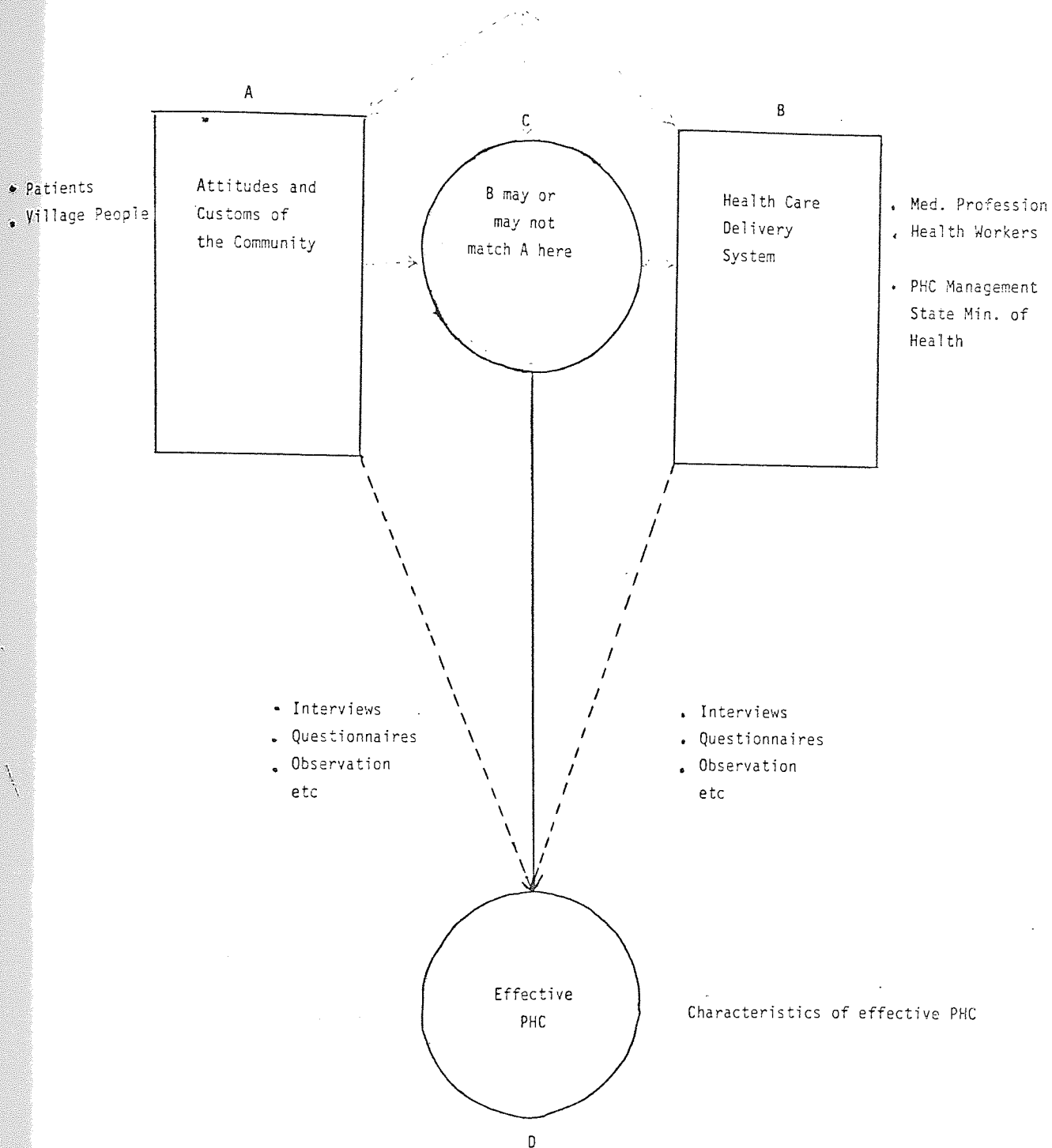


FIGURE 4

A SYSTEM'S VIEW REPRESENTING RESEARCH HYPOTHESIS

3. Mode of transport: bicycles, public transport, horse, camel, canoe, etc.
4. Costs in money, effort, inconvenience etc.
5. Travel times in hours and minutes
6. Home visits, first aid provisions

(ii) Economic Accessibility:

7. Ability of the individual or the community to cover the cost of care.

(iii) Cultural Accessibility.

Acceptability:

1. Acceptance of health services by the community which meet their health needs.

A comparative analysis can be made between various types of health care that are acceptable to the members of the community e.g. the villages may accept one or combination of these:

- . National Health Service (Government)
- . Private Health Care (Modern but private)
- . Traditional

2. Health care delivery which is consistent with local beliefs and traditions, e.g.

- . Female health workers to care for women.

3. Acceptance of health care of adequate quality.

Continuity:

1. Organising health services in a way that guarantees continuation of care e.g.
 - patients arrival and reception
 - examination and diagnosis
 - Discharge of outpatients
 - Referrals
 - Follow ups
 - Admissions - In-patients
 - Discharge Referrals
 - etc. Follow ups
2. Records and confidentiality: must be adequate and efficient:
 - Staff files
 - Clinical or medical records
 - Laboratory registers
 - Discharge and referral letters etc.
3. Ensuring that each health worker lives in his work area or near enough to it.
4. Satisfactory budgeting and budgetary control to prevent interruption of services, drugs, contraceptives etc.
5. Budgetary control in finance and accounting which includes:
 - i) capital expenditures
 - ii) the flow of capital
 - iii) the flow of cash and health authorities assets
 - iv) inventories
 - v) costs of various health activities.

6. Control of personnel management:
 - i) labour relations
 - ii) labour turnover
 - iii) wages and salary administration including labour costs
 - iv) absenteeism
 - v) safety (wastage, misuse, health etc)
7. Control of goods and services:
 - i) quality
 - ii) quantity
 - iii) cost
 - iv) output of machines
 - v) output of individuals.
8. Develop referral regulations
9. Co-ordinate development of new services
10. National planning.

Quality:

High quality services for example:

1. Increased skill of health staff through in-service training.
2. Improved supply of drugs and equipment according to the disease patterns of the community.
3. A good referral system.
4. Regular guidance and supervision.
5. Quality control of drugs, services, equipment etc.

Efficiency:

1. Economy of effort which is effective.
2. Value for money: Cost-effectiveness.

Good Management Activities at Village or Operations Level:

Management activities performed by those who fall outside the main stream of organised health system, namely:

- . Community Leaders
 - . Church' Leaders
 - . Women s Organisations
 - . Voluntary Agencies etc; who
1. create awareness within the community of the role and meaning of PHC.
 2. organise the community for participation in health development.
 3. collect, analyse data and identify health problems of the community
 4. co-ordinate logistical support for PHC services.
 5. provide feedback on effect of PHC services.

Management activities performed by those who work formally within the organised health system, namely:

- . Managers of Dispensaries
- . Managers of Health Centres and Clinics, Local

Hospitals

- Managers of PHC Teams
- Managers of specialised teams etc, who:

1. plan local health programmes
2. manage the implementation of local programmes
3. promote community health organization
4. co-ordinate external agency programmes and liaise them with state health services requirements
5. monitor, control and evaluate performance at local level.

Good Management Activities at State Ministry of Health (Intermediate)

Level:

Managers at this level serve the link between national and local (operations) level and their activities include:

1. Consolidation of plans and formulation of regional (national) policies and programmes
2. Design and operation of state/region-wide referral system
3. Adaptation and transmission of organisational plans and directives for management of health services including collaboration with other sectors.
4. Adaptation and definition of state requirements, standards etc pertaining to provision of health care services and administrative systems and procedures.
5. Monitoring and evaluation of progress and performance of programmes at state level.

Good Management Activities at Federal or National Level:

The policy-makers, planners and programme managers at national level would be engaged in the following activities:

1. assisting health policy-makers (ministers and senior politicians) in formulating broad policy guidelines or major health issues and programmes
2. long term national planning and programming of health services to implement the Government health policies
3. Mobilisation of political will and public opinion and support
4. Negotiating, obtaining and allocating resources at national level (material, manpower and money)
5. Setting national norms and standards and monitoring and evaluation progress and performance.

The Definition of "Health":

Health has been defined by WHO (1946) as a state of complete physical, mental, social and economic well-being, and not merely an absence of disease or infirmity.

A health system consists of interrelated components in homes, educational institutions, work places, communities, the health sector and other related sectors; action taken within one component affects the action to be taken within the others. The system includes a health infrastructure which provides health care to individuals, families and communities. Such health

care consists of a combination of promotive, preventive, curative and rehabilitative measures. The system is usually organized at various levels, the first of which is the point of contact between individuals and the system, where PHC is delivered, various intermediate and central levels provide more specialised services and support as they become more central.

The higher levels of the health system should support the first contact level of PHC to permit it to provide essential health care on a continuing basis; at intermediate levels more complex problems should be dealt with more skilled and specialized care, as well as logistic support should be provided and more highly trained staff should provide continuing training to PHC workers, as well as guidance to communities and community health workers on practical problems arising in connection with all aspects of PHC; the central level should co-ordinate all parts of the system, and provide planning and management expertise, highly specialized care and so on.

2.2.2 How to Define and Measure Effectiveness of PHC

Definition:

Effectiveness may be defined in terms of the degree of goal achievement

2. PHC Goals include:

- (a) PHC official and recognised goals that governments (especially in the developing nations) should aim to achieve Health For All By the Year 2000 (HFA/2000).
- (b) PHC operative goals - things the PHC management are trying to achieve through its operating policies.

PHC Effectiveness:

PHC effectiveness may be measured and determined in terms of some important independent, dependent and intervening variables.

Independent	Dependent variable
↓	↓
Cause	Effect

1. An independent variable, when varied, is assumed to result in changes in another, dependent variable.
2. A dependent variable is assumed to vary as a result of changes in one or more independent variables.
3. An intervening variable is an unobservable process or state that helps to clarify the link between an independent variable and a dependent variable.

Examples:

The Independent Variables - Age; health; experience; education; communication; training; intelligence etc.

The Dependent Variables may include - productivity, morale, conformity; adaptiveness; community acceptance and support, stability etc.

Each of these dependent variables can be defined also e.g.

1. Productivity may be defined as the ratio of output to input. High productivity is high output as a result of low input (finance, equipment, services etc)

Output:

- a. Number of out-patient visits per day, quarter, year etc in the out patient clinics, health centres, for the treatment of common diseases e.g.
malaria
tuberculosis
dyssentry
bronchitis, skin diseases etc.
 - b. Family planning: Maternal and child health visits made for
 - (i) Care of pregnant women
 - (ii) Assistance in delivery
 - (iii) Care of baby and child
 - (iv) Training of village midwives etc
2. Morale may be defined in terms of the degree to which the needs of the individual are satisfied.

If a high number of needs of a high number of individuals in a group are highly satisfied, then morale is high, but if the opposite is the case, then morale is low.

Satisfaction or fulfilment of needs along the entire range of the Need Hierarchy (e.g. Maslow's) for one particular individual or group may not always be possible but there can always be an acceptable compromise.

Motivation is a desire to act, for example, to obtain the necessities for life itself, for example,

- a) Food, shelter, clothing, rest and safety
- b) To satisfy social needs such as the need for companionship, for love and for position of respect
- c) To develop a measure of personal satisfaction. A person needs to feel comfortable with himself and with what he makes of his life and of his talents and abilities.

Motivation of work: Herzberg (1966) claimed that six main motivating factors in work are

- 1) Achievement
- 2) Recognition
- 3) The work itself
- 4) Responsibility
- 5) Advancement
- 6) Self-improvement

These motivators or satisfier factors should be directed to helping health workers to achieve work goals, explain the value of work, help them to take responsibilities, train for promotion and so on.

Herzberg's imperical investigation also identified what he called the maintenance hygiene factors, i.e. dissatisfiers or things that make people unhappy with their work namely:

- 1) Inefficient administration
- 2) Incompetent supervisor
- 3) Poor interpersonal relations
- 4) Personal qualities of the leader
- 5) Inadequate salaries
- 6) Bad working conditions

It therefore follows that for health workers to remain highly motivated in their work, PHC Managers would be encouraged to promote 'motivators' and remove 'dissatisfiers'. In this way, the morale of the staff at work remains very high, leading to higher efficiency in health care delivery activities.

3. Conformity may be defined in terms of attempting to bring about change in the community or in the individual. These through, for example:

- i) Community involvement and individual participation in PHC
- ii) Improvement of individual health status
- iii) Rehabilitation of ex-patients in the community
- iv) Community care
- v) Neighbourhood/Good Samaritan organisations

- vi) Reduced number of patients complaints due to improved conditions in the out-patient clinics, wards etc
- vii) Increased job opportunities in the rural areas.

4. Adaptiveness may be defined in terms of the degree of flexibility of PHC activities, for example:

- (i) Decentralization of the schemes e.g.
 - a) autonomy to make decisions at village level
 - b) training programmes
 - c) procedural re-organisation programmes.

Decentralization as against centralisation may achieve greater results in many situations .

- (ii) Increasing immunization programmes for children where mothers and the community at large have responded positively and accepted one or two of such earlier programmes as an effective campaign and measure against infectious diseases. In this way a wider coverage may be achieved.

If PHC activities are carried out to respond quickly to changing situations in accordance with local requirements or needs, then PHC is adaptable.

5. Community Acceptance and Support - this may refer to the degree of support PHC management, for example, is receiving from the rural environment. These, for example, may include the following activities:

- i) Having a good number of eligible villagers coming forward for PHW recruitment - lengthy lists of PHW job-applicants during normal economic conditions
- ii) Utilisation of community resources to advance PHC programmes
- iii) Reporting cases earlier for immediate diagnosis and prompt treatment
- iv) Voluntary and community service
- v) Positive public image of PHC
- vi) Positive attitudes of community to PHWs and to Primary Health Care Team.
- vii) Payment of wages/salaries of the PHWs through community subscriptions, donations, efforts etc
- viii) Community good relationships with community leaders, health authorities etc.
- ix) Arranging for mass immunisation and collection of children for vaccination
- x) Organising village cleanliness on a self-help basis
- xi) Forming village health committees to co-ordinate all health activities in the village

6. Stability: This may mean unit of purpose, lack of internal turbulence, consistency, absence of divisive community issues etc.

THE INTERVENING VARIABLES

At individual level the intervening variables may include:

- a) Habits and customs about sickness and treatment
- b) Level of literacy/illiteracy
- c) Public information channels
- d) Beliefs and attitudes of people
- e) Economic conditions etc

Therefore the independent, dependent and intervening variables may help to measure and determine PHC effectiveness based on:

Quality of health services, accessibility of services, appropriateness and continuity of services etc.

2.2.3 Measurement of Attitudes and Expectations

The terms attitude and expectation as used in the research hypothesis can be described or defined also. Formal definition of the term 'attitude' have been offered by a number of psychologists and other social scientists as the following selection would indicate:

- (i) An attitude is a hypothetical construct inferred from verbal expression and overt behaviour. It may be defined as certain regularities of an individual's feelings, thoughts and disposition to act toward some aspect of his environment (Secord and Backman, 1964)

- (ii) An attitude is a mental and neural state of readiness organised through experience, exerting a directive influence on an individual's response to all objects and situations with which it is associated (Allport, 1960).
- (iii) An attitude is a tendency to act towards or against some environmental factor which thereby becomes a positive or negative value (Bogardus, 1960).

The attitudes and expectations of people (communities) toward e.g. health care delivery system at village level may be undertaken through:

- a. Attitude and Opinion Measurement: Differences will exist amongst people's attitudes and opinions about certain events in the village. The following are ways of obtaining ideas and information on attitudes and opinions
 - a) Informally by interpreting chance remarks
 - b) Questionnaires - attitude scales
 - c) Opinion surveys
 - d) Interviews
 - e) Analysing changes in the village - improvement of environment, community development (etc).

7. Use of Likert-Type of Scale to Measure People's Attitudes:

Similar type of attitudes scale developed by Likert (1961) for measuring people's attitudes was used. Thus items were chosen by the investigator on the basis of experience, knowledge and theoretical definition.

Respondents were asked to indicate how far s/he agrees or disagrees with a statement. There are five choices namely:

Strongly agree value	= 1
Agree	2
Uncertain	3
Disagree	4
Strongly Disagree	5

Reliability and Validity of the Scale

- a. Reliability is the problem of the consistency of the measures of the scale.
- b. Validity is the simple question of whether a measure measures what it claims to measure.

Scales are particularly open to criticisms of reliability and validity. However, there are some methods which could be used to ascertain reliability of a scale e.g.

- 1. The test-retest method, this involves a second measurement with the same test over a period of time.
- 2. The equivalent forms method; here measurements on two comparable forms of the same test are to be applied etc.

Equally, validity of a measure could be determined through, for example,

1. The judgement by experts of the representativeness of the sample of items.
2. The measurement of known groups who should on priori grounds differ in an expected way on their attitudes etc.

Attitudes are also measured through:

- a) Structured interview e.g. purposeful conversations in which the interviewer may attempt to obtain an honest and complete answer from the respondent.
- b) Unstructured interview which is characterised by the free nature of discussion in which the interviewer sets the boundary of interview.

2.2.4 Matching Health Care Delivery System with Attitudes and Expectations of the Community:

If and when health care delivery system matches the attitudes and expectations of the village people, PHC is effective and may be characterised by the following as a check-list:-

1. A higher level of health
2. A reduction in the levels of illness, disability and death, particularly the death of children in the first year of life.
3. Higher average life expectancy.
4. Extensive application of scientific advances and new methods of diagnosis and treatment.
5. More scope for medical education based in the village.

6. Adequate coverage of health facilities in the rural areas.
7. Protection of environment and improvement of hygiene in the village.
8. Further development and improvement of the material and technical facilities available for health care provision.
9. Community involvement in PHC activities.
10. Ready access to essential health care and to the first-level referral facilities.
11. Safe drinking water provision.
12. Adequate nourishment for everybody in the community.
13. Proper immunization programme against major infections diseases of childhood.
14. Prevention and control of communicable diseases
15. Availability of essential drugs
16. Adequate transport and ambulance services
17. Logistics
18. Health education coverage
19. Trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age.

2.2.5 Appropriateness of Service to Village People or Patients.

Appropriateness of service to patient's condition may be seen from different viewpoints of primary health care services being provided in Nigeria. Appropriateness can be determined of certain services through observation of what the providers of the service do or through the reaction of the community/patients towards the existing health services available to them, for example:

1. People's acceptance or rejection of preventive health programmes
2. Number of children receiving or not receiving first, second, third doses of tetanus, toxoid or triple antigen will give an indication of people's involvement and their awareness of health care.
3. Reduction of common diseases in the community: diarrhoea, malaria, measles, cholera etc.
4. Reduction of such common diseases will testify the efficiency and effectiveness of primary health care and their cost-effectiveness is unquestionable
5. A number of well maintained pit latrines, pump wells etc
6. Family planning programmes and their acceptance
7. Reduction of infant and maternal mortality.
8. Control of communicable diseases
9. Some form of health insurance cover.
10. A marked change in the attitude of local people to accept new ideas about PHC, for example,
 - (i) increases in the use of latrines, refuse collection and refuse disposal etc can be observed
 - (ii) while in the beginning the sight of vaccination needles put many Nigerian children as well as their mothers to flight, the health workers (PHWs) now get frequently requested for immunization of children
 - (iii) Health centre or hospital treatment is wholly accepted and usually sought by almost everybody in the rural communities, although a few still seek traditional treatment in addition

- (iv) There is active involvement of village traditional birth attendant's traditional healers and the village people themselves in activities such as family planning and treatment of the common diseases in their villages
- (v) There is higher acceptance of the service and use of the health facilities available

11. People's attitude to health in general.

Appropriateness of service to patient's condition may also be determined through observation of the quality of basic health services being provided in the out-patient clinics to see if there are:

1. friendly and helpful reception
2. prompt unhurried attention at all stages of the clinic
3. compact grouping of facilities required for patient's visit
4. privacy and a satisfactory level of amenity
5. clear understanding of the advice given.

It is also possible to determine appropriateness of patient's service by observing work conditions at the clinic(s) and some of the facilities provided for the doctor's use, for example:

1. a suitable workload for each clinic session
2. patients available for consultation, with their case-notes (medical records) in orderly sequence
3. a quiet relaxed atmosphere for the clinic
4. accommodation which will enable the doctor to work without being impeded or cramped for space

5. access to full range of diagnostic and treatment facilities
6. efficient arrangement for dictation.

Similarly some nursing duties may be checked through observation to determine appropriateness of service:

1. a clear definition of her range of duties
2. time and opportunity for patient care
3. equipment in the right place
4. supervision by a departmental sister devoting her time essentially to co-ordination and supervision of nurses' work.

However, there are many other aspects of health care that can be considered to determine appropriateness of service to a patient, for example:

1. whether records on unexpected repeat visits are kept. The reason for such visits might include complications or the patient not following the treatment that has been prescribed or indeed, inappropriate diagnoses.
2. whether health professionals feel they are appropriately equipped with drugs, trained technicians, working equipment etc. to treat patients in their health centres, hospitals, maternity homes etc
3. whether health professionals feel they have to provide patient services which are inappropriate quality-wise because referral services are not available.

Specifically some of the measures of effectiveness of primary health care would be expressed in terms of the interests of:

- 1) Patients
- 2) Health workers
- 3) Communities, and
- 4) Primary health care management.

1. PATIENTS INTERESTS: Good medical care. What constitutes good medical care for patients may include some of the following measures: correct diagnosis; most effective treatment; information and reassurance about illness and prognosis., good nursing care - technical nursing care, kindness, cheerfulness and so on; good out-patient and in-patient amenities - good food, ample visiting, enough space and tidy environment for out-patient attendances etc.

Good medical care assessment: Patients and almost all laymen, have no qualification for judging quality of medical care and may not realise shortcomings in amenities such as food. Only a doctor's professional colleagues can assess the quality of medical care given to a patient as described in randomized control trials (RCTs) (Cochrane, 1972). Medical audit by senior medical staff on clinical work done is another method of assessment.

However, majority of Nigerian Health Authorities have not yet established grounds on which to judge the individual health centres, health clinics and hospitals, except:

- i) absence of complaints reaching them

- ii) statistics, especially cost figures and here low cost figures may reflect low standards in buildings, services, equipment (etc) rather than true economy which is defined as 'good housekeeping'
- iii) occasional contacts with senior members of health authorities rather than the health care facilities.

Assessment of good medical care is also difficult as staff are liable to transfer to the whole health care facility their opinion of their section or department: if, for example, a capable departmental manager ensures good working conditions, high job satisfaction (etc) his staff may assert 'this is a good health centre or hospital'. Staff are biased by "working group identity" sometimes.

Some Basic Health Conditions:

However, there are some basic health conditions which non-medical person can recognise and perhaps deal with e.g. primary health workers may be able to carry out some simple tests or recognise things that have gone wrong. The primary health worker may be able to observe particular conditions of some particular Nigerian communities for example, conditions like:

- i) Severe signs of malnutrition in a child: skin creases; eyes dull: does not eat; vomits; diarrhoea; fever; swelling of legs feet and hands; hair changes colour
- ii) Early signs of malnutrition: persistent crying; diarrhoea; getting thinner; not growing well
- iii) Observe how mothers feed their babies and talk to them

- iv) Observe local food habits and customs in the village, what food is available, watching and giving demonstration
- v) PHW can also control communicable diseases in the local community he is serving by:
 - a) performing vaccinations as requested by the health services, according to his supervisor's instruction
 - b) identify, treat, advise, and when necessary, refer patients with fever, diarrhoea and respiratory disease
 - c) prevent the spread of epidemics and keep his supervisor informed of the appearance of epidemic cases
 - d) give primary care for burns, wounds, fractures and bites and refer the patients when necessary
 - e) provide maternal care by identifying pregnant women in the community; advising them and referring abnormal cases to the health centre or the hospital; preparing for delivery, assisting at childbirth, giving first care to the mother and baby, calling for assistance or referring patients when necessary; giving post-natal care, advice and family planning information.

The factors that influence what the primary health worker(s) can do are claimed to be intrinsic and extrinsic factors (Werner, 1977). The intrinsic factors include:

- Cultural background
- level of literacy
- Personal factors
 - Compassion
 - integrity
 - judgement
 - initiative
 - perceptiveness
 - special talents
 - learning capacity
- acceptance of village health worker
- Local conditions and the PHC programme by the community
- Health priorities within the community
- Available funds with the community.

} factors that influence personal
potential of the village health -
worker

The extrinsic factors are those factor covering outside decisions and control. These include:

- attitudes, open or preconceived, as to what the PHW should be taught and permitted to do
- Length, content quality and appropriateness of training
- limitations of 'norms' imposed on health worker by outside authorities (e.g. Ministry of Health)
- Ability or inability of instructors and supervisors to build upon the existing knowledge, skills and cultural perspectives of the primary health worker
- Available funding from outside the community.

Furthermore, there are severe constraints to what the PHW can do alone without full assistance from the health team to which he belongs. What he does may depend to a large extent on what the other members of his health team are dealing with, as their functions are complementary and interrelated, for example:

- i) the physician at rural hospital may perform caesarean section;
- ii) the medical assistant or public health nurse at a rural health centre may insert intra uterine devices (IUDs);
- iii) the PHW may look after normal pregnant women and treat their minor ailments while he refers abnormal conditions to the nurse or physician.

2.2.6 Staff Interests:

As staff's outlook is largely - often wholly - shaped for good department management which entails:

- a) capable departmental head in terms of (i) technical proficiency, and (ii) managerial ability. When perhaps occasional unwise appointment of departmental head is made, staff may be resolute in remedying it, for example, either by arranging training, demotion, transfer, or ultimately by replacement of a boss.
- b) Administrator must give all possible help and support to each departments (i) in management and office matters in which he is expert: (ii) in checking for overloading of department, and taking action; (iii) in efficient co-ordination of work at all departments; (iv) in scrupulous attention to communications.

Management must follow whole-heartedly the recognised policies of welfare of staff, individually and collectively to help provide the right climate for harder and better work. Perhaps serving the staff's interest in this respect is also serving the patients' interest.

Efficiency and amity at the top are vital: Nursing officers, administrators, consultants and others must form a close partnership, disagreements being confined to the office or boardroom as open conflict, disloyalty and discord may spread to their subordinates.

Also, adequate training of the staff is crucial in order to overcome, prevent or reduce: (i) shortage and rapid turnover of staff; (ii) lack of motivation of staff., (iii) considerable demand for curative services (iv) training of health workers which tends to create bias in favour of clinical medicine, instead of various field programmes, (v) insufficient government support for preventive and educational programmes. Maslow (1943), Arygris (1962) have all stressed the importance of satisfaction of human needs in organisations, and also that by inhibiting the human aspects of individuals, organisations almost certainly sacrifice effectiveness. Many other writers such as Fayol (1949), Clarke (1960-61), Whyte (1963) also made similar assertions.

2.2.7 PHC Management:

PHC management should not continue to assess its basic health units (health centres, clinics etc) on: (i) statistics of cost figures, (ii) the negative evidence of lack of complaints, (iii) the subjective element of odd

personal contacts with senior officers. Both State Ministry of Health, and local government Health Authorities must exercise a clear supervisory role in PHC activities in the rural communities, as well as providing all the necessary support and resources for efficient health services. Furthermore, some form of Inspectorate of PHC activities must be introduced which compares favourably with those of Nigerian inspectors of:

- . Schools
- . Fire
- . Police
- . Mental Hospital Board of Control
- . Nursing Services
- . Ministry of Health audit of hospital accounts.

Any such inspectorate for PHC activities would have the duty, not just to possibly find out the state of PHC affairs, but also to positively assist a Health Centre, Health Clinic, Hospital to function both efficiently and economically.

The management should also develop health policies which must be consistent with the overall objectives of providing appropriate health care for the underserved populations which according to Bossert (1979); Fein (1975); Noble (1973); Golladay and Koch-Weser (1977);, Knox (1979) will best meet the immediate health needs of the individual country.

2.2.8 Rural Community Attitudes and Expectations:

Attitude creates attitude. Courtesy, tolerance, patience are some of the attitudes the villagers may expect from health workers when dealing with the community health problems.

The rural community may also expect some of the following:

- (i) Locating and localising health care facilities which offer:
accessibility in terms of a) distance 5-10 miles b) cost which the community can afford c) reasonable travel time period to reach these facilities
- (ii) Increased population coverage in terms of, for example,
 - a) No. of doctors and nurses per unit of population
 - b) No. of beds per unit of population
 - c) No. of people for whom a health centre has been established.
- (iii) Nearness of locations which offer Radii of about 5 miles (8 km) - 10 miles (16 km) catchment areas to the local people.

Acton (1975) observed that travel time functions as a price influencing demand for care. Kreysler (1970) found that area of influence of child health clinic in Kenya to be about 3.5 mile radius and only negligible utilization beyond this limit. Jolly and King (1966) claimed that out-patient visit in India are halved each $\frac{1}{2}$ mile of distance. Radii of 10 miles (16 km) or sometimes 5 miles (8 km) have gained widespread acceptance as effective catchment areas for rural health care facilities (Walker and Gish, 1977). It is also observed by Intaka (1966) that 45 percent of lower status

Brazilians interviewed stated that they lowered food consumption in order to balance family budget after using health services.

- iv) Adequate level of finance which must provide:
 - a) Not less than NIO (8:0) per head of population in the villages
 - b) Local health insurance cover: "Insured people make use of health care services more frequently than the uninsured" (Rosenthal, 1964)
 - c) Minimum prescription charges
 - d) Transport and ambulance services
 - e) Rural development
 - f) Recruitment, training and salaries of community health workers
- v) Bottom-up planning which must include:
 - a) Regrouping of vilages to sizeable districts or zones
 - b) Setting boundary divisions and co-terminosity of district areas
 - c) Selection of important problems of the community
 - d) Considering some available or alternative strategies to solving the community problems
 - e) Tabulating needed and available resources, (i.e.) balancing resources and needs of community
 - f) Mobilising community resources
 - g) Detailing activities
 - h) Writing a plan to tackling the important problems
 - i) Securing community involvement in planning and decision-making process.

- vi) Adequate information system which must be directed to:
 - a) communication and prevention in the community
 - b) defining community problems and the message
 - c) putting the information together
 - d) selecting the media which is locally-oriented.
- vii) Improving the present poor health care delivery system in Nigerian rural communities. Stock (1981) described the five negative images relating to the Western-type medical care in Nigeria: the organisation of health services within the facility; cultural discontinuities; credibility of Western-type medicine; quality of care and corruption.

2.3 THEORETICAL DESCRIPTION OF DIFFERENT METHODS OF DATA-COLLECTION, THEIR ADVANTAGES AND DISADVANTAGES

Data-collection tools are used in survey research to obtain standardised information from all subjects in the sample. The questionnaire and individual interview are the most common instruments for data collection in survey research, but there are others including observational methods as described by Bronislaw Malinowski (1922); Washington Conference (1976); M. Gary Easthorpe (1974); Desmond Morris (1977); Martin Trow (1980); M. Truzzi (1974); Goode and Hatt (1952) and Martin Bulmer (ed) (1982). The mail and telephone are yet, other methods of collecting data.

2.3.4 The Personal Interview:

Personal interviews are desirable when (1) the subject matter is complex,

(2) the inquiry is long (3) the survey seeks unstructured, open-ended information, and (4) answers from a sufficient number of respondents are not otherwise likely. Personal interview can be structured, semistructured or unstructured. The structured interview is standardised but some of the questions may also be open-ended if probing is required or used to obtain fuller answers from respondent. In the semi-structured interview the question content may be fixed but not the wording while the unstructured interview is used to probe the deepest and most subjective feelings of respondent.

Personal interview has some advantages: flexibility for the interviewer, better response rate, question order, environmental control, spontaneity, etc. may be achieved. Time of interview can be recorded and its effects analysed, also. But the disadvantages are many, including time consumption for travelling, visiting etc, inconvenience may arise, especially if the respondent is visited at wrong times when he or she is busy or does not want to see or talk to any interviewer without appointment.

There are other methods that can be used to collect survey information apart from personal interview, for example:

2.3.2 The Telephone Interview:

The telephone interview is one such method though in the Nigerian fieldwork context quite unrealistic. The advantage of the telephone interview is that it is a relatively quick method for obtaining certain kinds of information. Assuming that the questions asked of the respondent are not highly personal or too numerous, the researcher will probably be able to

collect information from a high percentage of his sample in a relative short time.

In contrast with the questionnaire and personal interview methods, the researcher need not arrange for appointments in advance, travel to subjects residences, or leave it to subjects to mail in survey information at their leisure. The obvious disadvantages of telephone interview are that relatively few questions can be asked, questions are not usually answered in depth, certain groups of respondents cannot be reached easily by phone, and the method becomes fairly expensive if a large, widely dispersed sample is surveyed. Also, since not everybody has a telephone, this type of interview imposes sampling limitations that may be inconsistent with the purposes of the survey. It is impossible to rely exclusively on survey by telephone, particularly if poor people are to be interviewed, for the data may be severely biased by exclusion the most deprived. Furthermore, in some localities, many people may have unlisted telephone numbers.

2.3.3 Records:

Another technique for collecting information is to examine records (medical records for example). Both in-patient and out-patient medical records often contain much information of interest to researchers; for example: patients' ages, income, occupations, marital status, medical treatment etc. Examination of medical records of patients if approved has the advantage of being relatively complete and quick, since all the relevant information is usually stored/filed in the medical records department. Of course, the researcher should be sensitive to the issue of invasion of privacy if this technique is used. Clearance from all involved groups should

be obtained before proceeding to examine patients medical records. This prevents litigation also.

2.3.4 • The Mail Survey:

Is another survey method which some researchers adopt. The mail survey can deal with a wide range of questions. If it is well conceived, clearly worded, and calls for multiple choice answers that are appropriate and easy to check, even people with little education can respond.

The major problem with mail questionnaires is that not everybody returns them. Returns may range from 5 to 98 percent, depending of course on the interest of the topic, the population queried, and the relevance and length of the questionnaire. Compared with the typical response rate for successful interview surveys (about 80 to 90 percent success), mail response rates for the general population rarely exceeds 50 percent without extensive follow-up. A low rate of mail return requires that data be treated with considerable scepticism in terms of their representativeness. The non-respondents may differ from the respondents in important but unspecific ways in mail survey and the results consequently are not representative of the population. Some studies (The Urban Institute, Washington D.C.) (Weiss C.H. and Halry H.P. 1970) have found that those with extreme views are more apt to respond while older and less-educated people and women are less apt to return mailed questionnaires. Returns can be boosted to relatively high levels by intensive efforts (such as letter or telephone follow-ups). A report by Anthansopoulos & Hochstim (1970) showed mail returns of 70 percent and over when follow-ups were used. However these extra efforts push up costs, while making the respondent

group more representative.

Obtaining mail addresses for all units to be sampled is another difficult and costly task. Some researchers and investigators tend to seek cutting mailing costs by sending questionnaires with other mailings, such as utility bills (gas, electricity, telephone etc). While this cost-saving device has some merit, it also has some limitations, for example: (1) the mailing list may not include all the people that the survey aims to reach (or the sample) and may include others not appropriate for the survey, and (2) the replies may be emotionally coloured by other items in the envelope (high or excessive bills: gas, electricity etc).

2.3.5 Personal Observation:

Observation of behaviour is widely used by many researchers as a method of data collection. Observation of behaviour is a rather impressionistic method, being non-statistical and difficult to quantify. It is perhaps the least desirable, yet it is widely used by many investigators. The validity of observation method rests on the observer, who can be influenced by his own bias or attitudes.

Furthermore, there are always problems with observational method, relating for example,

- (1) practical difficulties of classification, coding, quantifying
- (2) lack of control over variables
- (3) lack of anonymity thus difficulties in gaining entry
- (4) probably small and unrepresentative size of observed sample

- (5) errors of observation and interpretation may cause bias.

However, observational method also has some advantages, for example;

- (1) it is most useful as a rapid spot survey
- (2) it represents uncensored non-verbal data
- (3) the natural environment is often undisturbed
- (4) choice of covert or overt (participant or non-participant) is possible
- (5) can be conducted in depth/overtime, showing nuances and trends.

Investigators and researchers tend to prefer using one type of observation or another for data collection purposes and various types of observational methods may be used for data collection purposes, including:

- (1) Participant observation. Attempt is made to see the world from the point of view of those studied. Subjective and intuitive modes predominate in dealing with unique individuals by non-replicable techniques closed to public scrutiny: i.e. - it is unscientific.
- (2) Non-participant observation. Observer is covert and removed from subject of study, although observer's own perceptions colour interpretation, as do categories and ideas.
- (3) Unstructured field study. Often participant observation type, overt, in natural setting, undertaken in depth over long period.
- (4) Unstructured laboratory analysis. Either participant observation or non-participant observation type, overt or covert. Use of instruments or one-way mirror probable.
- (5) Structured field study. Categorised checklist of items to be

observed. Requirements of identical groups and of objectivity. However, many uncontrolled variables are in the field.

- (6) Structure laboratory analysis. Rigorous control in artificial environment. Assumption that uncontrolled variables do not affect outcome. Regularity and comparability are possible. Quantification often follows.
- (7) Semi-structured study. Natural setting plus pre-determined categories to allow later quantification. Situation, personage are still reactive. There is no control over extraneous variables, therefore no comparability.
- (8) Indirect observation. Useful when unwilling or unable to observe directly, so unobstrusive method selected.

VALIDITY: Direct observation of an act or event has a superior face validity over other methods which involve a survey, or telling, or recall. However, the desire for anonymity in sensitive areas of behaviour may cause embarrassed cover-ups and moves to match presumed norms or expectations of both interviewer/observer and subject. This is termed a reactive response (Gary Easthope, 1974 *ibid*).

Social reality is partially a construct arising from expectations and from the previous observations of the observer. Thus complete lack of expectations can also lead to invalidity when it comes to interpretation. Structure of study arising entirely from within takes time to form: and experience may be random and unspecific. Fatigue, tension, stress, hunger, fear, shock, surprise etc may invalidate observational analysis and results. Involuntary effects may take place upon the experienced phenomena.

RELIABILITY: Differences both between observers and over time undermine reliability. In many cases, no comparison is possible between observations or the constructs evolved to present them. The subjective understanding of the individual researcher and the training received may be different. Lack of quantification precludes application of statistical tests. In more structured situations where precise guidelines have been laid down and carried out by trained observers, categories can be cross-referenced and multi-observer scores can be tested for deviance.

USEFULNESS: Preliminary observational study may help focus on specific behaviour (previously known or unknown) appropriate for investigation. Data obtained from observational methods is not so much the product of the method as in the verbal survey method, or restrictive laboratory experiment. No time restriction pressurizes the observation situation, thus permitting longitudinal and wider studies. Emotions are not reduced to digits fed into a computer.

RESERVATIONS: Uncontrolled extraneous variables may affect data observed. Perceptions of behaviour are generally unquantifiable. Record of events as they occur is hard to categorise.

However, there seems to be common factors to all the various methods of collecting data that may affect response rates and these factors mainly relate to the questionnaires that have been used, for example, in terms of their (i) sponsorship, (ii) layout and attractiveness (iii) length, (iv) accompanying letter or items, (v) ease of completion, (vi) inducements for completing them, (vii) characteristics of the population being surveyed or sampled, and (viii) reminders and follow-ups for non-respondents.

2.4 DATA-COLLECTION METHODS FOR RESEARCH STUDY

A doctoral researcher in Primary Health Care Management programme such as this, must aim at convincing public sector officials, health and university authorities that although he is confronted with innumerable report and surveys throughout his doctoral studies, he must develop an understanding of research techniques and an ability to question methodology, but this does not necessarily mean showing one side of the coin only, but also showing the other side as well. This is why my earlier approach has been centred on theoretical descriptions of various data collection methods with the merits and the demerits of each.

The strong theme that emerged from all these theoretical descriptions is that I particularly favoured adopting a few of these methods and techniques for data collection purposes in my field work, and these include the following variety of techniques:

1. Questionnaires
2. Interviews
3. Personal observation

The task is also between choosing simple but limited number of data collection methods in such a wide area of studies as primary health care management and appropriate questionnaires that would be understood and easy for completion by the respondents. I tried to combined these two.

2.4.1 Reasons for Choosing 2.3.1.

In almost every state of Nigeria, or indeed, Nigeria as a whole, primary health care is presently being perceived as a new-wave of health revolution and this trend naturally has meant an even greater need for sound data collection and analysis in order to monitor the direction and state of primary health care development and its effectiveness, especially in key (PHC) activities such as government political will and commitment, community participation and decision-making and health planning, record keeping, purchasing and supplies and overall developmental activities in primary health care nationwide.

By adopting simple data collection methods and by using them in a natural environment that the researcher himself is accustomed to (I was born in a village), these data collection tools will equip me to gain that necessary practical experience and build up a systematic approach to problem-solving in the rural communities and in this way contribute in small ways to existing body of knowledge (e.g. gained from Doctoral Programme Studies, National Doctoral Students' Conferences, Seminars, symposia, formal and informal education) on the organisation and management of Primary Health Care activities. Because I mentioned a systematic approach to problem-solving, it will be very unjustified if I do not stipulate in general, that the various types of data collection methods and techniques I have chosen are designed to seek health information from respondents mainly in the rural communities and villages of Nigeria, which if usefully analysed may show, for example: some health coverage and accessibility trends, ways of improving community and public health in general, the effectiveness of primary health care programmes in some specific communities, adequacy

of health facilities that have been provided for health centres and clinics, adequacy of basic training in primary health care for health workers and primary health workers in particular, attitude of community to existing services, health problems of the greatest concern to village people, make some recommendations to decision-makers, especially at community and local authority levels (community leaders, community development officers etc) of possible way of improving basic health services in their localities, seeking information about successful and unsuccessful (PHC) programmes etc.

But more than all these, I tend to share some optimism that by confidently choosing simple data collection methods which are both Nigerian culture-specific, and Nigerian ethnic-oriented, the various methods and techniques I have adopted may strengthen and improve the quality of data I collected from the respondents and also give the communities real opportunity to participate in health matters and decisions that affect them, and also hopefully enlighten some health officials by giving them insight into research methods that can be appropriate for rural community health surveys. In addition to all these, the methods and techniques I have chosen may:

1. equip me to carry out studies on my own initiative
2. contribute to the existing body of knowledge on the organisation and management of not only health/PHC organisations but also other public sector organisations.
3. give future primary health care managers and researchers, particularly in Nigeria and Africa, some insight into research techniques in this relatively new field of studies (PHC management)

4. develop the necessary communication skills to deal with the public: verbal, written, numerically, graphically, group processes etc.
5. form part of a continuing education process in (PHC) which seeks to develop ability to detect problem situations, ability to identify the factors which will govern the nature of any solution or situation constraints etc
6. develop ability to acquire and use information: ability to locate and extract information, generate new information with surveys, apply information to the problem situation
7. develop and implement my field work time-table by adhering to data collection schedules as planned, while at the same time allowing provisions for unforeseen contingencies such as bad weather, shortage of funds, lack of transport, refusals and call backs on behalf of respondents etc.
8. keep a sustained effort in fieldwork programme with or without supervision
9. develop ability to produce work of an acceptable standard from both the university's point of view and from Health Managers viewpoints also.

The idea, however, is for me to be able to develop the ability to select the most appropriate methodologies and techniques in data collection processes that are suitable for Nigerian (PHC) situations which should be suitable and acceptable, bearing in mind that Nigeria is a large country (100 - 150 million) with diversities in culture, language, customs, traditions, beliefs, religion, health awareness and education, socio-economic and political activities etc., and evaluating and analysing their usefulness accordingly.

Beyond all these cultural and other constraints, there are other sensitive areas such as confidentiality of information and ethical problems which the research investigator has to be aware of and pilot his data-collection tools safely across them.

Having chosen the above data collection methods and techniques for my research, I must also emphasise that there might still be one or two pitfalls inherent in them. This is because in almost every research, investigators are faced with few rights and wrongs with respect to the research itself and the data-collection methods designed for it, and almost certainly, each idea put forward has to be judged on a wider set of criteria beyond just accept or reject conclusions in order to be able to fully judge the potential worth of one research idea and its methodologies against another. I tend to have some doubts and reservations as to, for example, how understandable and acceptable all my questionnaires and health attitude surveys would be to all my respondents and also how seriously people (mainly villagers) would be prepared to answer simple health questions (to me) with simple honest answers void of any tribal or political undertone: prominent features which characterise many third world countries problems and complicate deliberations in (PHC). All remains to be seen what happens in Nigeria, at least from the findings and results of the subsequent chapters on Data-Analysis where I have cautioned myself to develop some form of check-list of all data collected for analysis in a very comprehensive order viz:

2.5 THE CHECKLIST:

- i) All necessary information collected and effectively used.
- ii) Information obtained but not used to full effect.
- iii) Incomplete information used to a satisfactory effect.
- iv) Substantial omissions and some inefficient use.
- v) Very inadequate information, badly used.

PART II

CHAPTER THREE

FIELDWORK PROGRAMME

3.1 OBJECTIVE

In the previous chapter the important methodological tools for this research study were examined in detail and the most appropriate techniques were chosen. In this chapter, these variety of Research Methods that have been chosen are put into practice in the field work programme with a view to gather information from all the respondents in the villages. The main objective of this chapter is therefore to collect all the necessary data from the rural communities of study with which the research hypothesis would be tested.

3.2 THE SURVEY PROCEDURE

The idea was to interview outpatients prior to consultation - this avoided the very tricky question of access to case notes and any problems of confidentiality and gave the patients themselves the right to participate or not as they wished. To this end a few language interpreters (both for Hausa and Yoruba respectively) were required who assisted the investigator with language translations in all the interviews conducted in Hausa and Yoruba and in the completion of the questionnaires.

The months of August and September were chosen as the main period for the survey and these months were fortunately free of intensive farming

activities when local farmers are always away to the fields most of the time, leaving no adult at home to be interviewed. Also the two months (represented) a time when there was no industrial dispute amongst health workers. The weather was moderately cool in the south but warm in the north.

3.3 SAMPLING METHODS

The methods of sampling selected for use in the surveys include the following:

- a. Simple Random Sampling. This involved drawing units at random from the whole population. A table of random number was traditionally used.
- b. Cluster Sampling which involved batches of people who live near each other being selected, thus reducing travel time.
- c. Population figures from Local Government Census in the Internal Revenue division were used to estimate population of the three rural communities. These figures may not represent current population figures of the three communities.

Differences between the use of these sampling methods in the three rural communities of study:

1. Whilst the northern Hausa rural community, with its much scattered populations (10,000 plus) required the use of simple

random sampling, the two southern rural communities (Ibo and Yoruba) with their densely populated rural communities (5,777 and 5,000) were sampled in batches of clusters of people.

2. Difficulties in communications - irregular transport systems, bad roads, dusty roads, flooding in wet season etc. posed big problems more in the north than in the south where overflooding was the main problem during the fieldwork programme.

3.4 POPULATION SIZE

Three rural communities in Orumba County District (Ibo), Ibadana Local Government Area (Yoruba) and Kano Local Authority (Hausa) with different population densities - as stated in 3.3 above were chosen for field surveys. These population figures were the official population statistics obtained from the most recent and up-to-date Local Government census (the 1976 Nigerian Local Government Reorganisation Bulletin) figures.

SELECTION : The selection process of the three communities for the fieldwork programme was based on some important considerations. Firstly, informal visits were made to most of the rural communities in Ibo, Yoruba and Hausa provinces to observe and gauge the suitability of three of their rural communities for fieldwork studies.

During these informal visits, many community leaders and village people's views about their health services situations were taken into account in the

final selection of the three rural communities for field-surveys. Secondly, some formal contacts were made with the Local Government and Local Health Authorities and their officials in these areas of study who helped to identify community problems and to determine the levels of Primary Health Care development programmes in their respective regions. From the accounts given by these officials, the investigator was able to make a judgement of the three most suitable communities for study. The communities that were finally selected also have other important features which added weight to their selection, for example, they have, each made some progress in (PHC) development programmes, they are situated in different geographical regions, they are of different cultural backgrounds, they share similar socio-economic conditions etc.

3.5 HOUSEHOLD LISTING

For the purposes of the survey, the Household Listing was completed with the names of village people available from the local government Internal Revenue Headquarters in each of the local government areas. Official permission to obtain these important household statistical figures was sought by the investigator and given by Senior Internal Revenue Officers in each of the three provinces.

The list of names was deemed not to be completely up-to-date due to some significant occurrences e.g. it was stressed that in the rural communities in the south since the advent of oil-boom in the mid-seventies, the majority of village people migrated to cities in an alarming rate to seek gainful employment and improve social amenities.

3.6 SAMPLE SIZE

A systematic sample of clusters of village people was selected from all over Kawo, Orumba and Ibadana local government areas. Each cluster was made up of all the people living within a geographical area following the local government re-organisation programme of 1976 in Nigeria.

Thus the village people in the sample were geographically stratified in 10 clusters of household cells of 210 people in each cluster.

A total of 100 clusters having about 21,038 individuals, 10 clusters were chosen for the survey. These 10 clusters were found to be the most suitable and feasible sampling units for the rather scattered populations in these three rural communities of study. Also the 10 clusters represent about 10% of the total population of these areas.

3.7 PRE-EVENT TRIALS AND COLLECTION

Prior to the village interview and questionnaire distribution activities, a pre-event trial of the questionnaires designed for the field surveys was held at the University of Aston Management Centre in Birmingham (UK) with both the undergraduate, postgraduate and doctoral Nigerian students and a few non-Nigerian students to gauge their response and reaction to the questionnaire. A further field-trial was also conducted with the village people and some of the respondents in the sample. These pre-event trials proved invaluable and resulted in a much improved questionnaire that was finally distributed to all the respondents during the actual survey proceedings and activities. Key changes were made in the structure and wording of the questionnaires; questions were much simplified and better understood etc.

3.8 INTERVIEWS

1. The Interviewers

The use of five indigenous interviewers similar to both Yoruba and Hausa people served as bridge builders between the investigator and the people. These indigenous interviewers generated greater trust and were favourably received. They spoke and understood the language of the respondents, understood the customs and beliefs of the people, and above all made the local people feel that they were part of the Survey process.

2. Interviewers Selection and Training

Three of the interviewer assistants had completed five years of secondary education whilst the other two had had primary school education plus one year vocational training in Primary Health Care (Primary Health Workers). Criteria for their selection included residence in these rural communities; acceptance by the community and a proven capacity to interview people. The five of them received initial practical interview instruction and training from the investigator, who is also their supervisor. Training sessions were used to emphasise strongly, the need to state and interpret questions as written without substituting own versions; not misrecording answers given by respondents or introduce bias through gesture, facial expression etc. The investigator was able to supervise the five interview assistants to avoid errors.

3. The Village Interviews

The interviewer and the five assistants by using a pre-tested questionnaire asked respondents questions in english which was then translated to either

Hausa, Yoruba or pidgin english or any other local vernacular or appropriate lingua. As a result, no interview was discontinued on account of difficulty in communication. The interviewer and his assistants remained in every one of the three rural communities of study until they had completed interviewing all the people in the sample.

Most of the interviews were conducted early in the morning before people went to their farms and late in the evening when they returned home. Each villager's interview/Group Villagers interview on average lasted about 10-30 minutes.

A total of 1,200 Village Group/individual interviews were successfully undertaken. A further 210 questionnaires were completed by community people with respondents spending about thirty minutes on average in their completion. For both interviews and questionnaires, some questions were answered and others were not. The fieldwork survey programme and details are shown at the end of this chapter.

- b) In the out-patient survey, all the respondents were informed with the approval of the health centre authorities that the investigator was carrying out a survey which seeks improvement of PHC effectiveness in the local communities, and that the interviewer would come and ask him or her a few questions while he or she is waiting (in the out-patient clinic) and that the information gathered would be treated in the strictest confidence.

Certain basic guidelines were also followed in the process of all the interviews done at health centres and dispensaries, for example, the

research work should disrupt the normal routine of the health care facility as little as possible. Furthermore, every effort were made to minimise the time required to administer the questionnaire. Also, patients should not have to wait too long by waiting to be interviewed. These guidelines were considered necessary to ensure the full ongoing cooperation of overworked staff members and of patients who had already waited a considerable time for medical consultation and who often still had to proceed elsewhere to obtain prescribed drugs or therapy.

Each patients interview lasted about five minutes.

All the data collected, following interviews, were then coded by the interviewer, usually after the clinics or during any intermittent quiet period.

c) **Health Workers:**

The 100 questionnaires for health workers were distributed to them ahead of the day the interviews were scheduled. This meant that some of them were left with the choice of either completing the questionnaires in their offices/departments or at home, provided of course, they were able to return them in good time. There were no significant changes to the original questionnaires pre-tested with a few health workers who had no problems in completing them. The response rate was good with 80 of the questionnaires being completed and returned, five badly completed (omissions etc) and fifteen unreturned.

Non-responses: Inevitably, interviewers were unable to contact everybody in the sample and some people refused to be interviewed. The non-responses only represented about less than two percent because of a number of follow-ups made, which helped to gain access to some households and interview their occupants.

3.9 DIRECT PERSONAL OBSERVATION

1. Housing Conditions: A great part of the houses of people in the three communities was thatched and constructed with bamboo (about 68%). Windows are too tiny to provide adequate ventilation. The floors of a good number of houses are made of soils which have no protection against rising damp. Overcrowding is an acute problem with the sitting rooms serving as sleeping rooms in most of the homes.
2. Water: At all seasons, the village people's drinking water came from unprotected sources of wells and river water. Drinking water from these polluted sources is not always boiled. A few spring water sources provide clean drinking water but are situated well outside these communities, making access very difficult. About (75%) of people fetch their drinking water from rivers, about (15%) from wells and (10%) from spring sources.
3. Waste and Refuse Disposal. A few methods of disposing waste and refuse materials in these rural communities (5%) were observed, mainly thrown into special pits which are never deep enough. Otherwise, greater proportions of refuse waste are dumped around people's homes - this promotes fly breeding.

4. Transport and Communication: In the rainy season the roads are bad and muddy. The frequent heavy rainfalls do a great deal of damage to the roads, making them inaccessible. These roads are also badly maintained because of Governments' neglect and lack of funds for their improvement. The whole communities' infrastructure need some improvement. Also, the dry season is quite as damaging to these roads, because of heat, dust etc.

3.10 SUPPLEMENTARY SOURCES OF INFORMATION

The Supplementary Sources of information during field survey process included such sources like informal conversation and social contacts, for example, with friends, health centre and dispensary workers, religious and community leaders, school teachers, traditional birth attendants etc.

Also some useful information was gained from studying maps, census figures, especially the 1974 Local Government areas reorganisation programme. Information was also obtained from some published official reports, for example, about the 'National Sanitation Day' which is held once every month (Saturday) in state capitals which now extends to local government areas to improve sanitation standards in the rural communities. Some annual government health bulletins and reports were also other means from where data was gathered during the field work surveys.

3.11 THE CONFIDENTIALITY OF INFORMATION OBTAINED

The research investigation carried a high level of confidentiality and this meant guaranteeing that the individual replies on a topic are never divulged. To this end, respondents were told the purpose of the investigation - that the field surveys were part of a doctoral study in their rural communities which offers them the opportunity to give their opinions and reactions to services being provided for them. Some of the matters raised concern the relative successes and failures of basic health services being provided for the village people. Respondents were strongly given the promise that their replies to question(s) would be treated in the strictest confidence.

3.12 THE USEFULNESS OF THE FIELD SURVEY

The usefulness of the fieldwork can be seen from different viewpoints. From the investigators point of view, the investigation enabled him to acquire some field work experience which is worthy of his efforts, for example, the survey approach equipped him to carry out studies on his own initiatives, it also enabled him to contribute to the existing body of knowledge in (PHC) management process as shown under chapter 7, it also provided him with a fresh perspective of (PHC) organisations in Nigeria.

Further it helped to establish inter-relationships of the subject as shown under the sixth chapter (Data Analysis).

Again from a personal point of view, the field work survey formed part of an educative process for the investigator by helping him to detect some

health problems and to identify some of the important factors - a problem situation in the rural communities studied.

Above all the survey helped him to develop the ability to keep up a sustained effort without supervision.

From the community viewpoint, the field survey led to some social integration and brought both the suppliers of the service and the utilisers of the service together to seek ways of improvement of the (PHC) system. It also helped the people to become involved in not only the self-diagnosis of health and community problems but also raised people's consciousness, in genuinely getting involved in the problem-solving strategy for improved health care in their localities.

3.13 PROBLEMS ENCOUNTERED IN THE FIELD SURVEYS

Considering the size of the surveys carried out in the three rural communities, few problems were encountered, and only one or two might be considered serious but not directly related to survey proceedings:

3.13.1 Political Events

The very incident of military coup in Nigeria at the time of the fieldwork operations became a matter of personal concern.

While the impact of the military coup was disturbingly felt by every Nigerian citizen, to the investigator the coup temporarily set a panic mood and the thoughts whether calm was going to be restored quick enough for the fieldwork to continue became a serious matter.

However the country was quickly restored to normal day-to-day civilian activities and the fieldwork then went ahead uninterrupted.

The Nigerian police suspicion of Researchers and the Research materials (the health questionnaires and other important research documents etc) led to a full searching and scrutiny of all I was carrying. But no major difficulties arose and both the police and airport authorities in Nigeria cooperated and did not penalise or punish me for the research materials I had with me.

3.13.2 Personal Safety and Health

The investigator had a car crash, an accident which occurred on my way to the East (Ibo) and West (Yoruba) from the North (Hausa), off Auchi main junction. Luckily the five of us (passengers) survived the crash without any major injuries. However we were stranded at Auchi town where we stayed for over 15 hours before continuing with our journey.

13.3.3 Financial Problems

The other big worry during the fieldwork operations, was of course, financial problems. The original plan was that the World Health Organisation (WHO) was going to finance a greater part, if not all the research investigation activities following (WHO's) grant approval for the study. In effect, the grant money was not released for the fieldwork activities during the August-October field survey period. The investigator had to use his private funds to complete the fieldwork project. It is hoped

that the (WHO's) research grant would eventually come through from its African regional headquarters - Brazzaville.

3.14 GENERAL CONCLUSION

The fieldwork operations were worth doing in many respects. For one thing it helped the researcher to collect the important data from respondents in the three communities who were interviewed, who completed and returned questionnaires etc. It provided a platform for testing and investigating the research hypothesis at the operations level (i.e. the local community).

From personal viewpoint, the fieldwork programme(s) brought the investigator closest to the people and made him aware of the social problems of the people in these rural communities and their health needs etc. Furthermore, the fieldwork studies gave the investigator some insights into the customs and traditions of village people as well as their social organisations and institutions.

The fieldwork programme had its difficulties such as the ones I outlined under 13, but the overall results from the investigation outweigh all the problems encountered.

3.15 FIELDWORK SURVEY PROGRAMME IN EACH COMMUNITY

- Week 1 . Overall survey planning, design and direction
- . Listing the units (blocks, households, individuals, schools etc) to be sampled

- . Selecting the sample, preparing maps, instructions and assignment schedules
- . Developing the interview questionnaire, travel, interview

- Week 2
- . Distributing questionnaire, group discussion materials, instruction materials
 - . Interviewing.
 - . Editing, coding, tabulating etc
 - . Analysing data (prelim.)

Report writing and summaries.

3.16 SURVEY PROGRAMME ACTIVITIES

<u>DAY</u>	<u>TIME</u>	<u>SURVEY ACTIVITY</u>
	Morning	Collection of information from village office: map, population, land area, village organisational structure, schools etc.
MONDAY	Evening	Introduction to village head, community leaders etc.
	Morning	Define the sample of heads of households to be visited. Define size of sample.
TUESDAY	Evening	Household visits: Observe house conditions and hygiene; interview with husband and wife etc.

	Morning	Observe Primary schools, kindergarten, school health.
WEDNESDAY	Evening	Visit households in the survey.
	Morning	Summaries of work done.
THURSDAY	Evening	Reports of work done.
	Morning	Household visits; Health Centre/dispensary visits.
FRIDAY	Evening	Meeting with village and community leaders. Discussion about standard of hygiene and sanitation - latrines etc; family planning etc.
	Morning	Home visits and observation of community environment.
SATURDAY	Evening	Observation of Health-related sectors: agricultural practices, nutrition surveys etc.
	Morning	Summaries of work done.
SUNDAY	Evening	Reports of work done.

CHAPTER FOUR

DATA ANALYSIS

4.1 AIM

In this chapter the main task is to analyse all the data collected during field surveys. Respondents' answers should be classified, categorized and analysed in detail to show whether people were satisfied or dissatisfied with PHC services available to them in their local communities and consequently to assess whether PHC systems in their rural communities are effective or ineffective.

The data analysis falls into two main parts:

- Part I The Analysis of Data obtained from Group and individual interviews in the villages, and data obtained through personal observation of health events in the rural communities of study; and
- Part II Analysis of all data obtained through respondents' completion of health attitudes survey about health care provisions in their different localities.

4.2 GENERAL DISTRIBUTION OF FACTORS ABOUT RESPONDENTS

TABLE 1

MARITAL STATUS OF RESPONDENTS N = 580

	IBO %	YORUBA %	HAUSA %
Unmarried	15	20	18
Married	75	63	80
Divorced	10	17	2
Total	100	100	100

TABLE 2

AGE OF RESPONDENTS AND ESTIMATES N = 580

Years	IBO %	YORUBA %	HAUSA %
16 - 25	9	11	12
26 - 35	26	22	28
36 - 45	30	40	36
46+	35	17	24
Total	100	100	100

Table 2 shows the percentage of the 580 respondents that were interviewed according to their age-groups. The number of those eligible for interview by age, experience etc of the health issues being examined increased from one age group into another, with the highest concentration of adults

available for the interviews in the age groups 36-45; and 46 and over respectively.

TABLE 3

EDUCATION OF RESPONDENTS AND ESTIMATES N = 580

	IBO %	YORUBA %	HAUSA %
No Schooling	85	86	90
1 - 4 yrs	10	18	7
5 - 7 yrs	3	6	3
8 - 9 yrs	2	3	-
10+ yrs	-	1	-
Total	100	100	100

TABLE 4

OCCUPATION OF RESPONDENTS N = 580

	IBO %	YORUBA %	HAUSA %
Peasant Farmer	75	79	80
Informal employment (messenger, art, craft etc)	10	8	5
In Professional job (Teaching, nursing etc)	7	5	2
Community Leader	2	3	4
Others	6	5	9
Total	100	100	100

Whilst Table 3 shows age groups and formal education which respondents have had; Table 4 shows those who have had formal employment in the private or the public service sectors with local farm work being the predominant occupation of respondents in the three communities.

TABLE 5

RELIGION OF RESPONDENTS N = 580

	IBO %	YORUBA %	HAUSA %
Moslem	6	20	90
Protestants	30	25	4
Catholics	29	21	1
Spiritualism	5	8	1
Others	32	26	4
Total	100	100	100

Religious practices in Nigeria tend to be dominated by three main denominations - Islam, Protestant and Catholicism. Islam is much practised in the north with about 90% of the Hausas remaining strong Moslems. In the south, the Christian believers (the Protestants, Catholics etc) represent about 59 percent of the total population of the Ibos and 46 percent of Yorubas.

Spiritualism, and other religions are also evident.

PART 1

4.3 THE ANALYSIS OF DATA OBTAINED FROM INTERVIEWS AND PERSONAL OBSERVATION OF EVENTS IN THE COMMUNITY

COMMUNITY

AWARENESS, ACCESSIBILITY AND UTILIZATION OF HEALTH SERVICES: N = 580

On average, (40%) was aware that there was a government clinic in the neighbourhood or in their rural community. As illustrated below, an awareness of the clinic decreased with the increase of walking distance at which they live from the clinic.

TABLE 6

Walking distance between respondents residence and clinic N = 580		Aware of Clinic %	Not aware of Clinic %	Total %
1. Less than $\frac{1}{2}$ hr N = 150	Ibo	80	20	100
	Yoruba	75	25	100
	Hausa	87	13	100
2. $\frac{1}{2}$ hr - 1 hr N = 140	Ibo	60	40	100
	Yoruba	63	27	100
	Hausa	48	52	100
3. 1 hr - 2 hrs N = 130	Ibo	38	62	100
	Yoruba	39	64	100
	Hausa	20	80	100
4. 2 hrs - 3 hrs N = 160	Ibo	20	80	100
	Yoruba	15	85	100
	Hausa	8	92	100

For those who live within half an hour walking distance from the health centre/clinic about 80% on average was aware of the clinic, while for those living at a walking distance of 3 hours from the clinic in their community or neighbourhood about 25% on average knew there was a clinic.

The pattern of seeking care for those who are aware of the existence of clinic varies. From those who knew about the existence of the clinics, about 70% used to go there in case of illness, for the following reasons: because of satisfactory results they have had before (55.1%); nearby 35.1%, cheap (3.8%) and other reasons (6.0%).

The 30% who did not make regular use of the clinic also gave various reasons for their actions: distance (24%); no good results (12%); expensive (4%); other reasons (7%).

Reasons for Use or Non-Use of Clinic for Respondents aware of Clinic:

1. Regular use of Clinic (Ibo, Yorubua and Hausa):

<u>Reason</u>	<u>%</u>
a. Cheap	3.8
b. Good Results	55.1
c. Nearness	35.1
d. Others	6.0
Total	100

2. Non-use of Clinic (Ibo, Yoruba and Hausa):

<u>Reason</u>	<u>%</u>
a. Expensive	4
b. Bad result	12
c. Far distance	24
d. Others	60
Total	100

3. The reasons for those who are not aware of existence of clinic was not available for categorisation. However, the majority of such people are completely cut off from the rest of their provinces by high mountains, creeks and river delta, and other natural barriers. But does this justify reasons for village people in these provinces not to be aware of existence of clinics? The answer from majority of them include:

- a. Their governments (both state, local and federal) do not care for them and they remain the forgotten.
- b. They do not have influential people - politicians, community leaders etc, who can speak on their behalf and influence diversion of resources to their communities.
- c. Traditional medical system and individual self medication are equally held effective hence people do not remember seriously

seeking treatment in any other health institutions apart from theirs.

- d. Other reasons include that they, the village people of such remote and isolated communities, are able to purchase herbal remedies, consult traditional birth attendants, purchase patent drugs where they are available even when some of them are long-expired drugs unfit for human consumption.

Preferences for various treatment methods:

A variety of ill-health and health conditions were categorised under several treatment methods according to individual preference but for the first five common diseases selected amongst others, the preferences are shown as follows:

Malaria; complications of pregnancy and childbirth; malnutrition; measles and whooping cough amongst others are the main common ill-health and health-conditions. Peoples' preferences for treating them show wide variations such as the ongoing vaccination and general immunization in Nigerian rural communities of study are reflections of the percentages for measles and whooping cough at health centres (12% and 16%); chemist (6% and 6%); midwives (1% and 1%) and various combinations of treatment preference eg self-treatment plus health centre treatment, traditional plus modern etc represent (16% and 6%). People widely preferred treatment of malaria, complications of pregnancy and childbirth, malnutrition, measles and whooping cough by traditional means (30%, 15%, 20%, 35% and 34%) just as they do by shrine consultations (50%, 33%, 35%, 20% and 15%).

TABLE 7

Treatment Preference	Malaria N=120	Complications of Pregnancy Child Birth N = 145	Malnutrition N=110	Measles N=105	Whooping Cough N = 100
	%	%	%	%	%
Self-treatment	5	2	6	6	3
Health Centre	1	1	11	12	16
Shrine	50	33	35	20	15
Chemist	3	6	15	6	6
Pharmacy	2	-	2	-	1
Midwives	-	10	2	1	1
Religious healing	5	8	4	13	12
Traditional Birth Attendants	-	20	2	1	2
Bone setters	-	1	-	-	-
Traditional Healer	30	15	20	35	34
Any combination of above	3	2	1	16	6
Others	1	2	2	2	4
Total	100	100	100	100	100

A number of diseases however were categorised for combination of treatment, for example, leprosy especially as people tend not to report such illnesses publicly to avoid the obvious stigma attached to the sufferers socially. Nevertheless whilst some preferred modern treatment for leprosy, a greater number preferred traditional treatment for such chronic diseases like epilepsy, tuberculosis etc and mental illness.

For mental illness the over-whelming number of people agreed that the treatment for it should be traditional, since it is believed to have causal factors associated with devil or evil spirit.

Preferences for different treatment methods for different diseases are varied, for example, for children of the age group 0 - 4 years, greater use was preferred of health centres. Many adult age groups preferred one or the other treatment methods, whilst only a few approved and use some combinations of treatment methods - self plus modern, self plus traditional etc.

The individual or family experience which village people have had with various treatment methods influenced their opinions and consequently their preferences. Many villagers often remembered one or two close relations or friends who suffered chronic diseases/illness - epilepsy, mental illness etc. These people were the ones who cautioned that health centre or hospital treatment for such chronic diseases should not be made a priority but a last resort. Local remedies are advocated as the best therapeutic approach and hence preferred.

Prayer healing is gaining momentum amongst many but its preference is restricted to believers in such things like occult, magic, god, God, Islam, etc. These people remember some satisfactory results they have had with prayer healing which made their pains disappear. In contrast, some believe in the efficacy of prayer healing but still remember some occasions when they received some uncivil treatment from some prayer healing specialists and administrators, this being remembered as a product of personal experience or those of close relations.

Self-medication is common but has some limitations in terms of accurate self-diagnosis of illness and application of the right and useful medicines - tonic, headache pills, blood purifiers anti-malaria etc.

The test for support for health care provisions amongst the respondents in Table 8(a) had shown that in general majority of the people believed that health care provisions are both inadequate and unsatisfactory. Amongst all age groups, particular reference was made to poor quality and quantity and inaccessibility of service to the people. The intermittent services and break down of PHC systems are associated with bad management, lack of staff, corruption and the like. When asked the type of health care provisions standard they would like to have in their respective rural communities, a wide variety of answers emerged which emphasised the need for health care systems based on effective basic health care provision at the periphery and primary level; a thorough system of preventive care; a very high level of popular participation and involvement of the communities in health etc. which satisfy basic health needs of the people, given them easy access and high quality service that are acceptable to them.

TABLE 8(a)

Support for Health Care Provisions

Age Group	Accessibility	Acceptability	Continuity	Quality	Efficacy of Treatment
	%	%	%	%	%
16-21 (N=150)	38	23	35	40	33
22-34 (N=120)	26	31	26	25	20
35-41 (N=200)	21	24	24	22	22
42 + (N=110)	15	22	15	13	25
Total	100	100	100	100	100

PATIENTS' SURVEY N = 210 (Ibo, Yoruba and Hausa)

When 210 out-patients were interviewed and asked "have you found health Centre/dispensary satisfactory in its care of patients?" responses emerged as follows:

On average those satisfied with health centre/dispensary services and care were very few from the total number ie

$$\frac{5 + 10 + 3\%}{3} = 6\%$$

But the number of those who were generally dissatisfied with health centre/dispensary services and care in the three communities, on average was very high ie

$$\frac{95 + 90 + 97\%}{3} = 94\%$$

The reasons and options of those who were dissatisfied have been used to test the research hypothesis in greater details in chapter 5.4.1.

TABLE 8(b)

No of Out patients	Service	V. satisf	satisf	Undecided	Unsatisf	V. satisf	Total
Ibo N = 70	Health Centre/ dispensary	-	5	-	95	-	100
Yoruba N = 70	Health Centre/ dispensary	-	10	-	90	-	100
Hausa N = 70	Health Centre/	-	3	-	97	-	100

Total N = 210

TABLE 9

Village People gave (PHC) top priority for extra (Govt.) Cash

Priorities for extra public expenditure N = 580

	<u>First Priority</u>	<u>Second Priority</u>
PHC/Health	51	25
Education	20	29
Agriculture	10	10
Housing	6	15
Rural Development:		
water supply	14	21
roads		
transport etc		
Total	100	100

TABLE 10

CHOICES BETWEEN TAX CUTS AND PHC SPENDING N = 580

AGE GROUP	Reduce taxes and expenditure %	Maintain taxes and expenditure %	Maintain taxes and increase expenditure %	Increase taxes and expenditure %	Total
16 - 21	5	8	84	3	100
22 - 34	3	15	56	26	100
35 - 41	2	12	67	19	100
42+	12	10	76	2	100

On series of questions to test support for PHC, the survey shows that fewer village people are ready to support reductions when linked to tax cuts. The vast majority of people want to maintain the present level of taxes in their respective communities and increase in public expenditure for PHC as shown under table 2. Only about one quarter of the people interviewed are ready to increase taxation to increase services.

Greater priority was given to PHC services (see table 1) than might have been expected, particularly from amongst the villagers living in the remote and isolated communities, which suggest that PHC services were indeed seen as national rather than just village community issue. Analysis also reveal a remarkable gulf between the aspirations of the village people and the rhetoric of Nigerian governments - Federal, State and local administrations - and their concern for the majority of people living in the rural communities in reality. The apparent response from the few who wanted tax and expenditure cuts will surely not be sustained when it is realised that this would mean further cuts in the PHC services. The main issue that divided people was not reduction versus expansion in the real sense of PHC situations in the rural Nigeria but the relative merit of maintenance or expansion when the village people themselves say that they are not receiving from the providers of service the type of service they require at the time they needed it, and at a cost they could afford and in the manner acceptable to the people. The majority of those who did not favour increase in taxation for increase in PHC services were the old people, the unemployed and the uneducated. The survey suggests the support shown amongst the age group 22 - 34, to be due to reasons eg full-employment or having large families needing health and other social services etc.

There was strong support for extra spending on PHC services amongst all age groups.

TABLE 11

FAMILY PLANNING

ATTITUDE, KNOWLEDGE AND PRACTICE OF FAMILY PLANNING
N = 300.

Age Group	Those who have heard about F P %	Those who have not %	Total
16 - 21	35	65	100
22 - 34	30	70	100
35 - 41	20	80	100
42+	15	85	100

Of the 300 respondents, the number of people who have heard about family planning amongst all the age groups is small (75), leaving the rest as those who have not heard anything about family planning.

For those who knew something about (FP), knowledge of (FP) came from the following sources:

SOURCES OF KNOWLEDGE FOR THOSE WHO HAVE HEARD ABOUT
FAMILY PLANNING N = 75

Source	%
1. Village official	18
2. Village meetings	15
3. Family planning field workers	8
4. Religious officials	10
5. Public Health officials from Ministry of Health	17
6. Friends and Neighbours	5
7. Health Centre Staff	12
8. Radio	4
9. Newspapers (Local)	4
10. Husband and wife	2
11. Family members	-
12. Traditional birth attendants	2
13. Others	2
Total	100

Amongst those who have heard about family planning, half of them did not understand the methods for using a contraceptive device; about one quarter had some understanding of the use of one or more methods; less than two thirds of the remaining people had a good understanding of how to use one or more methods - condom, oral, oestrogen, IUD etc.

The most well known contraceptive methods are IUD, oral pill and condom.

OBJECTIVES OF FAMILY PLANNING

For people who had not some understanding of the use and objectives of family planning, several reasons were outlined to be responsible as stated below:

Reasons for not having a clear understanding

of the objectives of (Fp N = 3000

%

Lack of knowledge on variety of contraceptive methods

18

Desire for a large family

24

The importance of having a son

20

Religious beliefs (Moslems, Catholics and Protestants

13

Culture and tradition and superstition

19

Any combination of the above

2

Others

3

Totals

100

Not all have have heard about family planning had clear understanding of (FP).

Amongst respondents (about 50%) of those who understood the objectives well, less than one third agreed and less than one quarter did not agree with the practice of modern family planning system but rather agreed with the traditional family planning system (Traditional methods). This is because of peoples' different beliefs, customs and traditions. The majority of people who resent family planning and birth control may be grouped as follows:

- i) The Moslems who reject any interception of natural progression of pregnancy through any artificial means - all should be left in the hands of Allah (Islamic God).
- ii) Catholics who strongly oppose abortion on moral grounds.
- iii) The Protestants who question the moral and ethical issues surrounding peoples' decisions to terminate pregnancies, believing strongly that life does start early and should not be destroyed once conception has taken place.
- iv) Culturally, a typical Nigerian takes great pride in the number of children he has - the more children, the better.

In the past children helped families in domestic work and were used as cheap labour in the farm. But this attitude is slowly changing. This is because nowadays, children tend to represent economic liability to parents (eg school fees, job and vocational training etc).

- v) A greater number of village people (husbands and wives favour having the right to decide freely and responsibly the number and spacing of their children and to have the information and education to do so.
- vi) Men tend to make final decisions of the number of children their family should have.
- vii) Political debate as to the best approach forward to control population nationally is slow and surrounded with controversies as to what would be the best strategy acceptable to the people. There had been no attempts for the introduction of penalties, legislation, public debates etc against high birth rates. However, governments seem to be relying upon the Ministries of Health and education to work together to achieve a wider recognition of the importance of family planning

PREFERENCE FOR USE OF TRADITIONAL MEDICINE: N = 300

When asked to state preference between traditional medicine and modern medicine and reasons for preferences, people's responses are as follows:

Preference for use of Traditional medicine to modern form of therapy was about 65 percent. Of the village people who favoured seeking health care with traditional medical establishments instead of health centres/dispensaries:

About half of those who preferred traditional medicine said that :

- a) Traditional healers are both cheap and resonable from financial point of view and its practitioners understand the culture - customs, traditions of beliefs etc of the people.
- b) That traditional medicine is both effective and efficient and had kept many village people, alive prior to the advent of health centres and dispensaries (modern medical care).
- c) That traditional system is an ongoing cultural establishment of the people and therefore culture - specific.
- d) The remaining half of respondents gave variety of reasons for their preference for seeking health care with the traditional systems, for example, a few of them recalled one or several incidents in which some of their close relations who had health centre/hospital treatment returned home worse off than they were (deterioration of health) before they went for modern health care. Others believed that it was a mockery of their tradition and culture to abandon original health systems (traditional) which their ancestors used most frequently. Yet others believed that any medical care void of rituals, long incantations, sacrifices to ancestors and the spirits of both the living and the dead has no real practical effect and subsequently no meaning to patients.

Of the remaining 35 percent of respondents, only 20 percent would prefer modern medicine if basic health facilities are improved. Minority of

respondents blamed government for not providing health clinics for their people who often had to travel several miles before they could obtain any basic medication. Added to this absence of basic health care facilities in these rural and isolated villages, the people claimed that they have had no real improvements of roads, seasonal overflowing, environmental health and no government's money for rural development in their rural communities. The other 15 percent of respondents said they would prefer to combine both forms of therapies where the ultimate outcome would be a recovery from illness, or health problem.

DIRECT PERSONAL OBSERVATION

1. ENVIRONMENT SANITATION

The general standard of hygiene in people's homes is still poor. Most of the houses have inadequate ventilation systems and the homes are constructed with impermanent material - bamboo, grass, etc which do not prevent or stop dampness in people's homes. The floor mostly consisted of soil only a small part had a floor covered with cement or brick. Not all houses had a separate bed room. In many cases the sitting room served as sleeping room at the same time

2. WATER

There was not much difference in the use of drinking water between wet or the dry season. In both seasons most water for drinking purposes came from unprotected sources; spring water nearby the village; wells without stone wall; river water and other unprotected source. A small part of

drinking water only came from protected sources eg well with stone wall; isolated springs outside the village piped water; pump water; and other protected sources. Drinking water was not always boiled before use. People say that if they boil their drinking water, the taste of the water is never the same and they do not enjoy it.

3. WASTE AND REFUSE DISPOSAL

Of several methods that could be used to dispose wastes and refuse: only a small portion was buried in the garden or thrown into a special pit or gathered in a refuse dump. Otherwise, wastes and refuse are still thrown away in any place around the house.

4. DISPOSAL OF HUMAN EXCRETA

Most people in the three rural areas still go to the river to defecate, some go to the field or in the yard and only a small number of people make use of their own latrines. Only very few of the houses had own latrines, of which nearly all are not used regularly. As a consequence, more and more attention is being focused upon the need for sanitary latrines and better waste disposal systems.

Observation shows that fewer than 18 percent of all homes in all the three communities have any form of latrines. Random counts indicated that only about ten percent of 160 homes observed have sanitary latrines. There are many reasons that have been established for this low percentage figures of both the number and use of latrines:

- a) The average farmer and his family in each of the communities have not adapted themselves to the modern use of sanitary toilets.
- b) Majority of Hansa village people still defecate in gutter, public places and in the bush.
- c) A few people have constructed latrines but do not make use of them in practice, as attempts to avoid the bad side of latrines at home; for example, its odour, cost, danger etc. Therefore village people who do not accept and construct latrines, or who constructed latrines but do not make use of them believe quite strongly that the smell of latrines in the homes is bad enough, so is the high costs of their construction. Fear of danger is related to the point that sometimes children end up falling through a badly constructed latrine. Even adults also do fall through, just as domestic animals also fall victims.

Although one may accept some of these reasons, one may also attribute the lagging behind of latrine construction or its use amongst the village people to the other factors. As observed in my extensive field observations and the interviews I held with people many factors lead to apathy of people towards latrine construction campaign in these rural communities and these include: lack of education, the little information (health education) available, false sense of security from both endemic and infectious diseases, indifference due to superstition and long standing traditions, low

income, inadequate supervision of location, design, and construction of latrines by local environmental health personnel.

5. HEALTH FACILITIES

The existing basic facilities in the rural communities are small when compared or matched with the number of village people that should utilise them. Of those that are in existence, most of the facilities need to be upgraded, replaced or expanded to improve services.

PART II

4.4 THE ANALYSIS OF DATA OBTAINED FROM HEALTH ATTITUDES QUESTIONNAIRE

QUANTITATIVE ANALYSIS WITH HARRIS 800 SYSTEM

1. Introduction:

In this section the HARRIS 800 system at the University of Aston, Birmingham was used to analyse all the data obtained from the questionnaires completed and returned by the Health Workers and members of rural community in Ibo, Yoruba and Hausa Communities.

The Registration on HARRIS 800 system was particularly relevant to this section because the system does provide access to running batch jobs, simplifies file handling and more importantly, has condensive statistical facilities for data analysis.

2. The HARRIS Advisory Service at Aston:

The free HARRIS Advisory Service at the University of Aston Management Centre/Computer Department was very helpful in the early stages of data preparations and consequently to the data analysis itself. The HARRIS Advisory Service was given by members/experts who know more about the system than others. Their advice proved to be quite beneficial to my completing the data analysis successfully.

This Advisory Service emphasised how and where to obtain useful information and how to operate the system; and also gives important guidelines - HARRIS INTRODUCTORY USER GUIDE; AN INTRODUCTION TO SPSS ON ASTON'S HARRIS 500/800 SYSTEMS; INTRODUCTION TO THE COMPUTING SERVICE GENERALLY.

3. The Problems that were encountered and overcome in data analysis:

The preparation of data cards and the subsequent punching system took a long while because of several mechanical and operational difficulties with the old HARRIS model at the university. A number of the HARRIS systems at some stages of the process of data analysis broke down repeatedly. This created a large volume of backlog and workload for many final year research students.

The alternative system (the Floppy Disc System) was introduced at onetime but only lasted a short while before it was replaced due to the technical problems associated with it. Now of course with the introduction of the new HARRIS 500/800 systems, data analysis at the Aston University is progressing much more rapidly than before and a

number of research students are happy with the authorities for providing the current computer facilities.

CHOICE OF STATISTICAL PACKAGE FOR DATA ANALYSIS

- a) **Condescriptive Statistics:** This was the statistical package used to analyse data in this section.

Condescriptive approach was chosen because it produces descriptive statistics which have been considered most appropriate to this section, and certainly most applicable to numerical variables such as the ones contained in the questionnaires. Condescriptive statistics are also thought to provide that necessary framework which links both Sections I and II of the data analysis.

- b) **Statistical Procedures:** Three kinds of cards have been used to define the statistical procedures used to analyse data in this section viz;

- i) Task Card(s) which defined the statistical procedure used -
CONDESCRIPTIVE - the variables on which it is performed: VAROOI
- VAR005.

- ii) The Option Card(s) which specified the choice made within the procedure i.e. how the missing data, if any were handled.

- iii) Statistical Card(s) which specified the statistics required for analysing data:

1. Frequences - General = VAROOI to VAR005

2. Options - Missing Values VAROOI to VARO05 (-1)
3. Statistics:
 - . Frequencies General = All
 - . Frequencies General - VAROOI to VARO05
 - . Condescriptive Variable List
 - . Relationships between two or more variables
e.g. Pearson Corr. to produce coefficients between variables.

CHECK-LIST FOR QUANTITATIVE ANALYSIS

A check-list was developed to cover all the information and data obtained from respondents. For the purpose of detailed analysis of data, this check-list has been divided up into eight main headings as follows:

1. ADATA = Health Workers; BDATA = Rural Community Members.
2. Necessary Information Collected and effectively used:
(Qs 1, 2, 4, 8, 9, 12, 13, 18: ADATA/BDATA).
3. Information obtained but not used to full effect:
(Qs 3, 5, 6, 7, 10, 14, 15, 16, 17, 19 & 21 ADATA/BDATA)
4. Incomplete information and used to a satisfactory effect:
(0)
5. Incomplete information not used to a satisfactory effect:
(Qs 22-24: PHC Managers)

6. Substantial omissions and some inefficient use:
(0)
7. Very inadequate information badly used:
(0)
8. Non-responses (29: ADATA/BDATA).

USE OF VARIABLE CODES:

Category 1: Code

1 = Yes

2 = NO

Category 2: Code

1 = Strongly Agree

2 = Agree

3 = Undecided

4 = Disagree

5 = Strongly Disagree

Category 3: Code

1 = Strongly Agree

2 = Agree

3 = Disagree

4 = Strongly Disagree

HEALTH ATTITUDES SURVEY A (IBO, YORUBA AND HAUSA)

HEALTH WORKERS

N = 80

Community Health Needs

Q1 What do you think are the main areas of greatest health need in your local community:

Health Facilities:

1. More rural health centres and clinics?
2. More hospitals for out-patient, in-patient and referral services?

Drugs and Materials:

1. More vaccines?
2. More refrigerators?
3. More essential drugs?

RESPONSES TO Q1.

Community Health Needs:

Various answers were given to this question with about 68% of respondents expressing that more health facilities, especially health centres and dispensaries should be provided in their rural communities and more importantly, that essential drugs and materials are vitally needed in these areas as illustrated with Tables 12-15 below:

TABLE 12

HEALTH FACILITIES Q1:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	55	68.8	68.8	68.8
2.	25	31.3	31.3	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 13

FACILITIES Q2:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	5	6.3	6.3	6.3
2.	22	27.5	27.5	33.7
3.	8	10.0	10.0	43.8
4.	27	33.7	33.7	77.5
5.	18	22.5	22.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 14

DRUGS & MATERIALS Q13:

Category Label Code	Absolute Relative		Adjusted	Cum
	Freq.	Freq.		
		(PCT)	(PCT)	(PCT)
1.	13	16.2	16.2	16.2
2.	59	73.3	73.3	90.0
3.	6	7.5	7.5	97.5
4.	2	2.5	2.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 15

DRUGS & MATERIALS Q2:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	16	20.0	20.0	20.0
2.	16	20.0	20.0	40.0
3.	23	28.7	28.7	68.8
4.	25	31.3	31.3	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

HEALTH ATTITUDES SURVEY A (IBO, YORUBA AND HAUSA)

HEALTH WORKERS

N = 80

Community Health Problems

Q2. To what extent do the following affect your community:

1. Malnutrition or 'kwashiorkor'?
2. Malaria
3. Complications of pregnancy and labour?
4. Insect and snake bites?
5. Insufficient drugs?
6. Inaccessible and isolated villages?

RESPONSES TO Q2:

Community Health Problems:

The majority of respondents (about 78%) agreed that the most important health problems in their rural communities are malnutrition, malaria, maternal and child health problems and other preventable diseases. Tables 16-21 below show the full details of both absolute and relative frequencies of answers to this question.

TABLE 16

COMMUNITY HEALTH PROBLEMS 1:

Category Label Code	Absolute Relative		Adjusted	Cum
	Freq.	Freq.		
		(PCT)	(PCT)	(PCT)
1.	9	11.3	11.3	11.3
2.	53	66.2	66.2	77.5
3.	1	1.2	1.2	78.7
4.	11	13.8	13.8	92.5
5.	6	7.5	7.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 17

COMMUNITY HEALTH PROBLEMS 2:

Category Label Code	Absolute	Relative	Adjusted	Cum
	Freq.	Freq.	Freq.	Freq.
		(PCT)	(PCT)	(PCT)
1.	19	23.8	23.8	23.8
2.	61	76.2	76.2	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 18

COMMUNITY HEALTH PROBLEMS 3:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	9	11.3	11.3	11.3
2.	62	77.5	77.5	88.7
3.	2	2.5	2.5	91.2
4.	4	5.0	5.0	96.2
5.	3	3.8	3.8	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 19

COMMUNITY HEALTH PROBLEMS 4:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	11	13.8	13.8	13.8
2.	69	86.2	86.2	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 20

COMMUNITY HEALTH PROBLEMS 5:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	1	1.2	1.2	1.2
2.	39	48.8	48.8	50.0
3.	34	42.5	42.5	92.5
4.	3	3.8	3.8	96.5
5.	3	3.8	3.8	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 21

COMMUNITY HEALTH PROBLEMS 6:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	23	28.7	28.7	28.7
2.	28	35.0	35.0	63.7
3.	2	2.5	2.5	66.2
4.	17	21.3	21.3	87.5
5.	10	12.5	12.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

HEALTH ATTITUDES SURVEY A (IBO, YORUBA AND HAUSA)

HEALTH WORKERS

N = 80

Community Sanitary Provisions:

Q4. How would you describe the following in your community:

1. Access to water
2. A sewage system
3. Pit latrine
4. Piped water to individual houses
5. Water Sources
6. Sanitary facilities.

RESPONSES TO Q4.

Community Sanitary Provisions:

About 78% of the respondents described the sanitary provisions in their communities as both inadequate and unsatisfactory. The main concern is about absence of sanitary facilities such as pit latrine, clean water system, and sewage provisions, as shown in Tables below:

RESPONSES TO Q1-3.

TABLE 22

COMMUNITY SANITARY PROVISIONS 1:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	19	23.8	23.8	23.8
2.	32	40.0	40.0	63.7
3.	3	3.8	3.8	67.5
4.	21	26.3	26.3	93.8
5.	5	6.3	6.3	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 23

COMMUNITY SANITARY PROVISIONS 2:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	1	1.2	1.2	1.2
2.	4	5.0	5.0	6.3
3.	50	62.5	62.5	68.8
4.	25	31.3	31.3	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 24

COMMUNITY SANITARY PROVISIONS 3:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	1	1.2	1.2	1.2
2.	1	1.2	1.2	2.5
3.	48	60.0	60.0	62.5
4.	30	37.5	37.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

HEALTH ATTITUDES SURVEY A (IBO, YORUBA AND HAUSA).

HEALTH WORKERS

N = 80

Community Health Education

Q8. Which of the following would you include in a health education programme for your village people:

1. Personal hygiene practices
2. Methods of supplying safe drinking water
3. Housing and home improvement

RESPONSE TO Q8.

Community Health Education:

Varied answers (Tables 25-27) were given to this question by respondents with the majority of people expressing different views on the kind of educational programmes they would like to be part of educational programme for their people e.g. personal hygiene practices 61%, methods of supplying safe drinking water 52%. However, a body of opinion also was expressed which preferred such educational programmes to include ways of increasing community awareness in matters such as community health education, the out reach of the existing programmes, and a system to encourage feedback from the community.

TABLE 25

COMMUNITY HEALTH EDUCATION 1:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	59	73.7	73.7	73.7
2.	21	26.3	26.3	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 26

COMMUNITY HEALTH EDUCATION 2:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	42	52.5	52.5	52.5
2.	38	47.5	47.5	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

TABLE 27

COMMUNITY HEALTH EDUCATION 3:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	17	21.3	21.3	21.3
2.	63	78.7	78.7	100.0
Total	80	100.0	100.0	

VALID CASES = 80

MISSING CASES = 0

HEALTH ATTITUDES SURVEY B (IBO, YORUBA AND HAUSA)

MEMBERS OF THE COMMUNITY

N = 79

Available Health Facilities in the Community:

Q9. What are the health facilities made available to your community?

RESPONSES TO Q9.

Available Health Facilities in the Community.

Here about 66 percent of respondents stated that they do not have any form of government health facilities in their rural community. Only about 33 percent said that they have dispensaries and health centres in their rural community. With fewer health facilities in most of the areas, access to even basic health care is difficult.

TABLE 28

AVAILABLE HEALTH FACILITIES:

Category Label Code	Absolute Freq.	Relative Freq. (PCT)	Adjusted Freq. (PCT)	Cum Freq. (PCT)
1.	26	32.9	32.9	32.9
2.	53	67.1	67.1	100.0
Total	79	100.0	100.0	

VALID CASES = 79

MISSING CASES = 0

HEALTH ATTITUDES SURVEY B (IBO, YORUBA AND HAUSA)
MEMBERS OF THE COMMUNITY

N = 79

Family Planning in the Village

Q12. The concern of some families in your village about contraception may include lack of knowledge on the variety of contraceptive methods; desire for a large family; cultural and religious beliefs etc.

RESPONSES TO Q12.

Family Planning in the Village:

Education and contraceptive devices have never received positive response amongst many Nigerian families as indicated in the answers to this question. About 72 percent of the village people expressed the views that the obstacles to a successful family planning strategy can be reflected on people's wish to have large families. In addition to this, cultural and religious beliefs of the people act as barrier, as extended family system and general attitudes to having as many children as one is blessed with, still holds.

4.5 SOME STATISTICAL TEST BETWEEN SOME VARIABLE TO SHOW PHC INEFFECTIVENESS IN THE RURAL COMMUNITIES

In both sections I and II of Data Analysis, some tables, for example, Table 8, Table 6 and so on tend to show that there are correlations between some variables and PHC ineffectiveness in the three rural communities of study.

The Chi-Square tests of significance - the most common convention accepted by statisticians - have been used to demonstrate the statistical significance of results shown in these tables as follows:

i) Statistical Significance of CHI - Square Tests :

Let p represent the probability (percentage) that the results occurred by chance rather than because of a relationship between the variables; then

	p Values	Significance of Relationship (Terminology)
i	$p > 0.05 (5\%)$	Not significant
ii	$0.05 (5\%) \geq p > 0.01 (1\%)$	significant
iii	$0.01 (1\%) \geq p > 0.001 (0.1\%)$	Highly significant
iv	$0.001 (0.1\%) \geq p$	Very highly significant

III THE APPLICATION OF CHI-SQUARE TEST OF SIGNIFICANCE

TABLE 8 SUPPORT FOR HEALTH CARE PROVISIONS AMONGST DIFFERENT AGE GROUPS

TABLE 8.1 Table shows observed Frequencies, E_{ij} , and (in Brackets) the expected Frequencies, O_{ij} , to Questions indicated

Age Group	Accessibility	Acceptability	Continuity	Quality	Efficacy	Total
16-21	57 (38)	35 (37)	35 (39)	60 (42)	50 (38)	150 R_1
22-34	31 (30)	37 (30)	31 (31)	30 (34)	24 (30)	120 R_2
35-41	42 (51)	48 (50)	48 (51)	44 (56)	44 (50)	200 R_3
42+	17 (28)	24 (27)	17 (28)	28 (31)	28 (28)	110 R_4
Total	147	144	149	162	146	T=580

$$\sum_{i=1}^4 \sum_{j=1}^5 \frac{(O_{ij} - E_{ij})^2}{E_{ij}} = \chi^2$$

Degrees of Freedom = $(r-1)(c-1) = 12$
 $r = 4; c = 5$

Let R_i = total in Row i
 C_j = total in Column j and T = grand total

Then $E_{ij} = \frac{R_i \times C_j}{T}$

$$\sum_{i=1}^r R_i = \sum_{j=1}^c C_j$$

$$\text{Then } E_{ij} = \frac{R_i \times C_j}{T} = \sum_{\text{all } i} R_i = \sum_{\text{all } j} C_j$$

E_{ij} are calculated on the assumption (null hypothesis that "age" and "answer" are independent).

Then the Expected Frequencies are as follows:

C ₁	1	$150 \times 147 \div 580 = 38$
	2	$120 \times 147 \div 580 = 30$
	3	$200 \times 147 \div 580 = 51$
	4	$110 \times 147 \div 580 = 28$

C ₂	1	$150 \times 147 \div 580 = 37$
	2	$120 \times 147 \div 580 = 30$
	3	$200 \times 147 \div 580 = 50$
	4	$110 \times 147 \div 580 = 27$

C ₃	1	$150 \times 147 \div 580 = 39$
	2	$120 \times 147 \div 580 = 31$
	3	$200 \times 147 \div 580 = 51$
	4	$110 \times 147 \div 580 = 28$

C ₄	1	$150 \times 147 \div 580 = 42$
	2	$120 \times 147 \div 580 = 34$
	3	$200 \times 147 \div 580 = 56$
	4	$110 \times 147 \div 580 = 31$

C ₅	1	$150 \times 147 \div 580 = 38$
	2	$120 \times 147 \div 580 = 30$
	3	$200 \times 147 \div 580 = 50$
	4	$110 \times 147 \div 580 = 28$

TABLE 8.2

Row i	Col j	Obs Freq o _{ij}	Exp Freq E _{ij}	Contb to X ² (O _{ij} -E _{ij}) ² /E _{ij}
1	1	57	38	9.5
	2	35	37	0.108
	3	53	39	5.025
	4	60	42	7.714
	5	50	38	3.789
2	1	31	30	0.033
	2	37	30	1.633
	3	31	31	0.0
	4	30	34	0.4705
	5	24	30	1.2
3	1	42	51	1.588
	2	48	50	0.08
	3	48	51	0.176
	4	44	56	2.571
	5	44	50	0.72
4	1	17	28	4.321
	2	24	27	0.333
	3	17	28	4.321
	4	28	31	0.290
	5	28	28	0.0

$$\Sigma = X^2 \text{ Calc.}$$

Very
highly
signif.
= 43.873

Then to compare X² Calc. with percentage pts
for X² with (r-1)(c-1) = (4-1)(5-1) = 12

$\Sigma = X^2$
Very
highly
signif.
(0.1%)
= 43.873

PERCENTAGE POINTS OF THE χ^2 -DISTRIBUTION

ϕ or ν	99%	97.5%	95%	90%	50%	10%	5%	2.5%	1%	0.1%
1	0.000	0.001	0.004	0.016	0.455	2.71	3.84	5.02	6.63	10.83
2	.020	.051	.103	.211	1.39	4.61	5.99	7.38	9.21	13.82
3	.115	.216	.352	.584	2.37	6.25	7.81	9.35	11.34	16.27
4	.297	.484	.711	1.06	3.36	7.78	9.49	11.14	13.28	18.47
5	.554	.831	1.15	1.61	4.35	9.24	11.07	12.83	15.09	20.52
6	.872	1.24	1.64	2.20	5.35	10.64	12.59	14.45	16.81	22.46
7	1.24	1.69	2.17	2.83	6.35	12.02	14.07	16.01	18.48	24.32
8	1.65	2.18	2.73	3.49	7.34	13.36	15.51	17.53	20.09	26.13
9	2.09	2.70	3.33	4.17	8.34	14.68	16.92	19.02	21.67	27.88
10	2.56	3.25	3.94	4.87	9.34	15.99	18.31	20.48	23.21	29.59
11	3.05	3.82	4.57	5.58	10.34	17.28	19.68	21.92	24.73	31.26
12	3.57	4.40	5.23	6.30	11.34	18.55	<u>21.03</u>	23.34	<u>26.22</u>	<u>32.91</u>
13	4.11	5.01	5.87	7.04	12.34	19.81	22.36	24.74	27.69	34.53
14	4.66	5.63	6.57	7.79	13.34	21.06	23.68	26.12	29.14	36.12
15	5.23	6.26	7.26	8.55	14.34	22.31	25.00	27.49	30.58	37.70
16	5.81	6.91	7.96	9.31	15.34	23.54	26.30	28.85	32.00	39.25
17	6.41	7.56	8.67	10.09	16.34	24.77	27.59	30.19	33.41	40.79
18	7.01	8.23	9.39	10.86	17.34	25.99	28.87	31.53	34.81	42.31
19	7.63	8.91	10.12	11.65	18.34	27.20	30.14	32.85	36.19	43.82
20	8.26	9.59	10.85	12.44	19.34	28.41	31.41	34.17	37.57	45.32
21	8.90	10.28	11.59	13.24	20.34	29.62	32.67	35.48	38.93	46.80
22	9.54	10.98	12.34	14.04	21.34	30.81	33.92	36.78	40.29	48.27
23	10.20	11.69	13.09	14.85	22.34	32.01	35.17	38.08	41.64	49.73
24	10.86	12.40	13.85	15.66	23.34	33.20	36.42	39.36	42.98	51.18
25	11.52	13.12	14.61	16.47	24.34	34.38	37.65	40.65	44.31	52.62
26	12.20	13.84	15.38	17.29	25.34	35.56	38.89	41.92	45.64	54.05
27	12.88	14.57	16.15	18.11	26.34	36.74	40.11	43.19	46.96	55.48
28	13.56	15.31	16.93	18.94	27.34	37.92	41.34	44.46	48.28	56.89
29	14.26	16.05	17.71	19.77	28.34	39.09	42.56	45.72	49.59	58.30
30	14.95	16.79	18.49	20.60	29.34	40.26	43.77	46.98	50.89	59.70

The test (Table 8.1) indicates that there are low percentages in the categories of respondents who answered "yes" to the questions, and high percentages of people who said "no" to the same questions. The answers (variables) shown in (Table 8.2) demonstrates that there are statistical significant relationships between the age groups and these variables.

The differences between the age groups were evident as shown in part 1 section of data analysis e.g. between the age group 16-21 and the rest; with the former maintaining that they did have access to health care provisions in their local communities (38%); that these services were uninterrupted at all time (23%); that the quality of such services was good (35%) etc. However, the percentage of those who said 'yes' to the questions decreased with age, with the only exception in the Age Group 35-41. The explanation to this development in this age group (35-41) was not clear but it is thought to be due to the fact that the greater number of respondents in this age group were mostly people with greater enthusiasm for both modern and traditional health care who tended to classify both as equally important to them, especially from the view points of traditional birth attendants, modern child care nutrition education etc.

Therefore with χ^2 calculations result (43.873) in Table 8.2, which is greater than 32.91 (0.1%); there are "very highly significant" relationships between the categories (i.e. age groups) and the answers (variables) given to the questions asked (i.e. on accessibility, acceptability, continuity, quality etc) of health care provisions in the rural communities of study.

The test for support for health care provisions amongst the respondents show that in general, majority of the people believed that health care provisions in their localities are both inadequate and unsatisfactory. Amongst all age groups, particular references were made to poor quality and quantity, and inaccessibility of the service to the people. The intermittent services and breakdown of PHC systems are associated with bad management, lack of staff, corruption and the like.

In all the categories the statistical results (both observed and unobserved) show that the village people have negative attitudes towards services being provided for them. These results have positively shown that PHC services in the rural communities are ineffective, especially when considered from the following viewpoints:

1. Poverty and socio-economic conditions: Poverty is a serious obstacle to people's health in the rural Nigeria due to low income or no income at all. In such a situation, families are rarely able to pay for health services even at lower costs.

Often there is no work in these rural communities and people drift into cities in large numbers in search of work. Basic services such as clean water, sanitation and refuse collection are inadequate. Homes are constructed of impermanent materials and overcrowding adds to health problems. Health services are thinly spread and in most areas are rarely within walking distance, making access to health care difficult in terms of distance, travel cost, travel time etc. Permanent insecurity is the condition of the poor in these communities, because there are no public systems of social security in the event of unemployment, sickness or death of a wage-earner in the family. Malnutrition, illiteracy, disease, high birth rates, unemployment and low income affect the majority of the people in the rural areas.

2. People's culture and tradition: In rural Nigeria, whilst there may be certain cultural and traditional practices of the village people which have no effects or which are beneficial to health (e.g.

breast feeding), there are also practices which may be positively harmful. Some of the Nigerian cultural and traditional practices on matters of health are harmful and have been observed in a number of areas: for example, why are most of the Nigerian village people so loath to accepting family planning? The answers from the majority of respondents interviewed in the village certainly showed that this has something to do with the custom of the people in terms of family size; the rejection of contraceptive devices, religious beliefs and moral issues of the people.

Many families preferred to have large families rather than to limit them; and the idea of contraceptive methods, and family planning system are very unpopular to many villagers especially from their religious and moral point of view. Termination of pregnancy, for whatever reason, is both culturally and religiously unacceptable.

Many families force themselves into unnecessary dietary restrictions in rural Nigeria due to their local customs and beliefs about them. The majority of the people believe in certain food taboos, for example, pregnant mothers eating fresh meat are believed to suffer from excessive bleeding after the baby is delivered and their healing process delayed.

Difficulties in health practices of the Nigerian village people are not restricted to customs, beliefs, attitudes, values, traditions and moral codes of the people only but also to other problems, for example, problems of communication and culture-gap between the providers of the service and the receivers. Those who introduce PHC services to the village people have not studied how

Equally disturbing, the Nigerian PHC system is much weakened by the considerable demand for curative services which leaves few resources available for preventive and educational programmes.

4. Governments policies;

The Nigerian governments' policies on PHC services lack both the will and determination to make the system to succeed. There is almost total lack of commitment on the part of Nigerian governments to provide adequate resources to improve services in the rural areas and to finance some important programmes, for example, by locating health facilities and health care delivery in areas where they are most needed.

5.

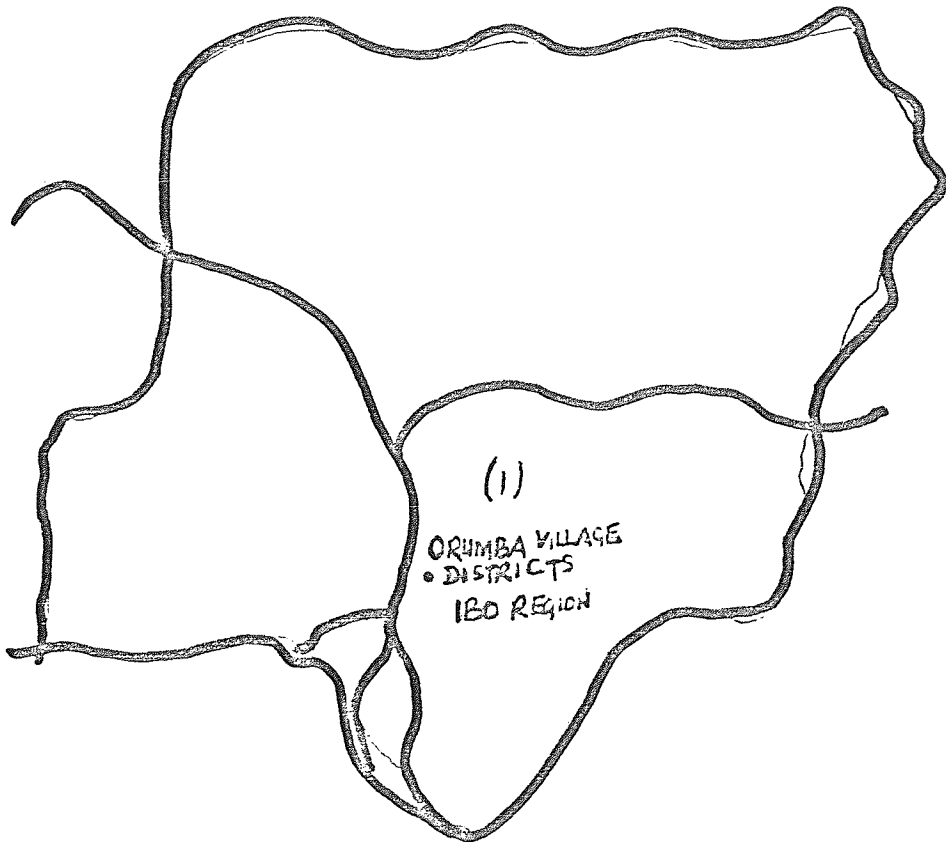
The similarities and differences of the Ibo, Yoruba and Hausa rural communities show some correlation with PHC ineffectiveness in rural Nigeria. These similarities and differences are observed in some important areas, for example, in health education - family planning; and hygiene and sanitation etc.

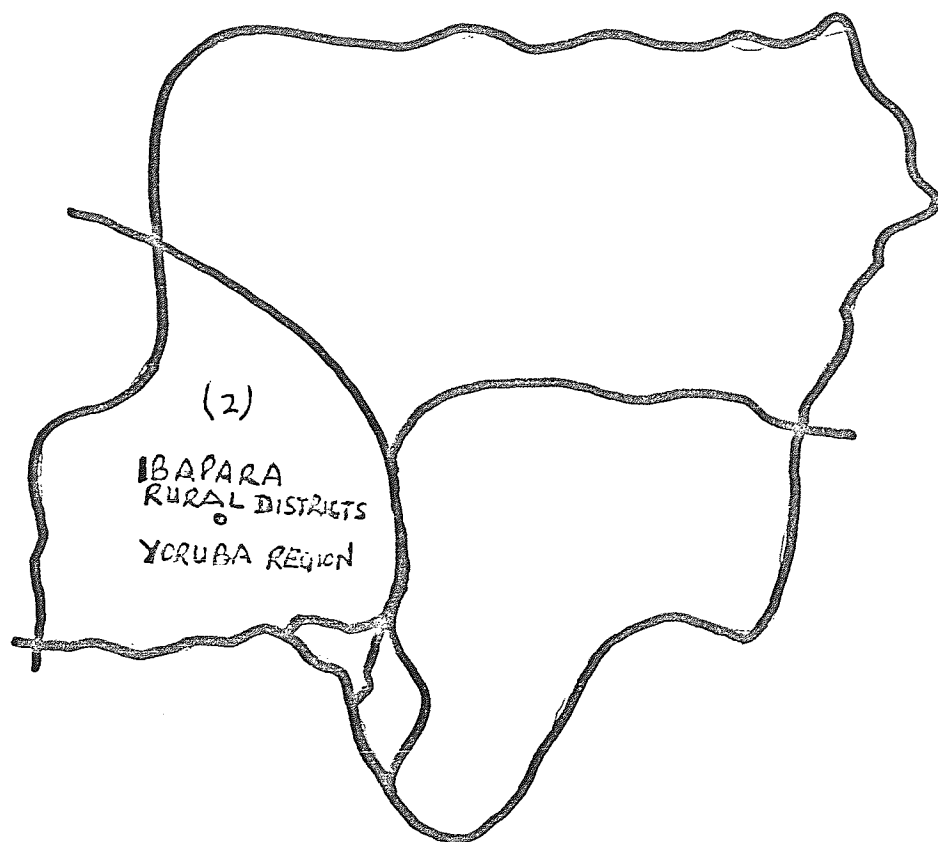
SIMILARITIES: Table 33

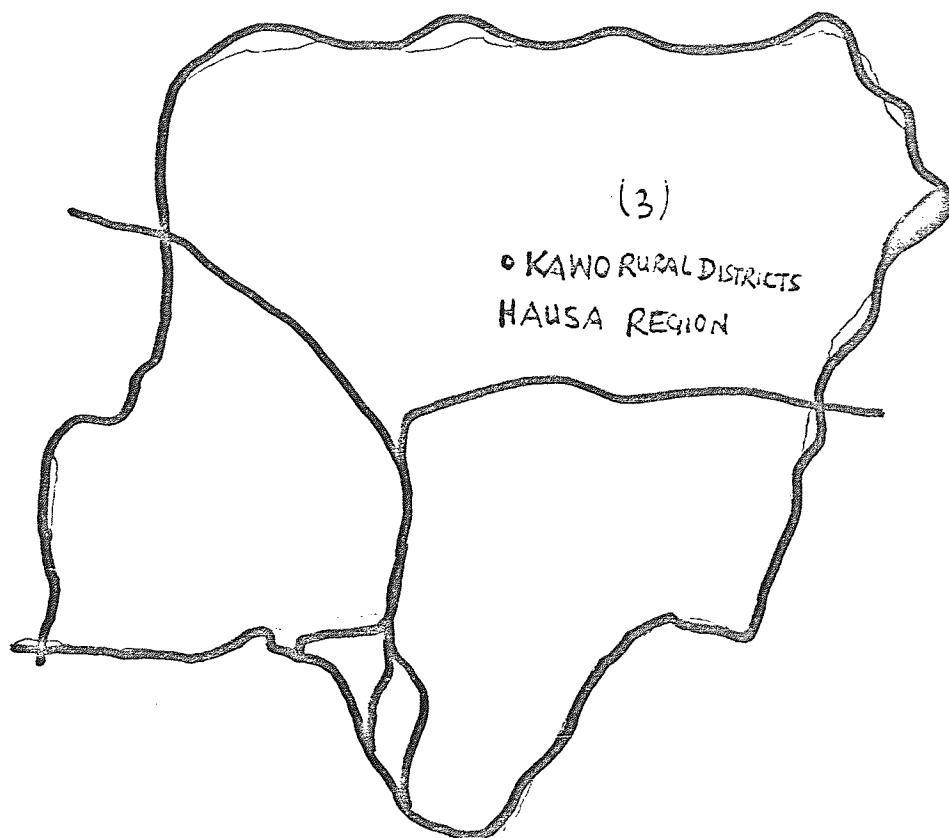
Area of Service	Ibo	Yoruba	Hausa
	1. Desire a large family	Desire a large family	Desire a large family
	2. Very important to have a son in the family	Very important to have a son in the family	Very important to have a son in the family
	3. Use of traditional birth control methods is common	Use of traditional birth control methods is common	Use of traditional birth control methods is common
	4. Very often seek the advice of TBA locally in pregnancy and delivery matters and delivery matters	Very often seek the advice of TBA in pregnancy and delivery matters	Very often seek the advice of TBA in pregnancy and delivery matters

DIFFERENCES: Table 34

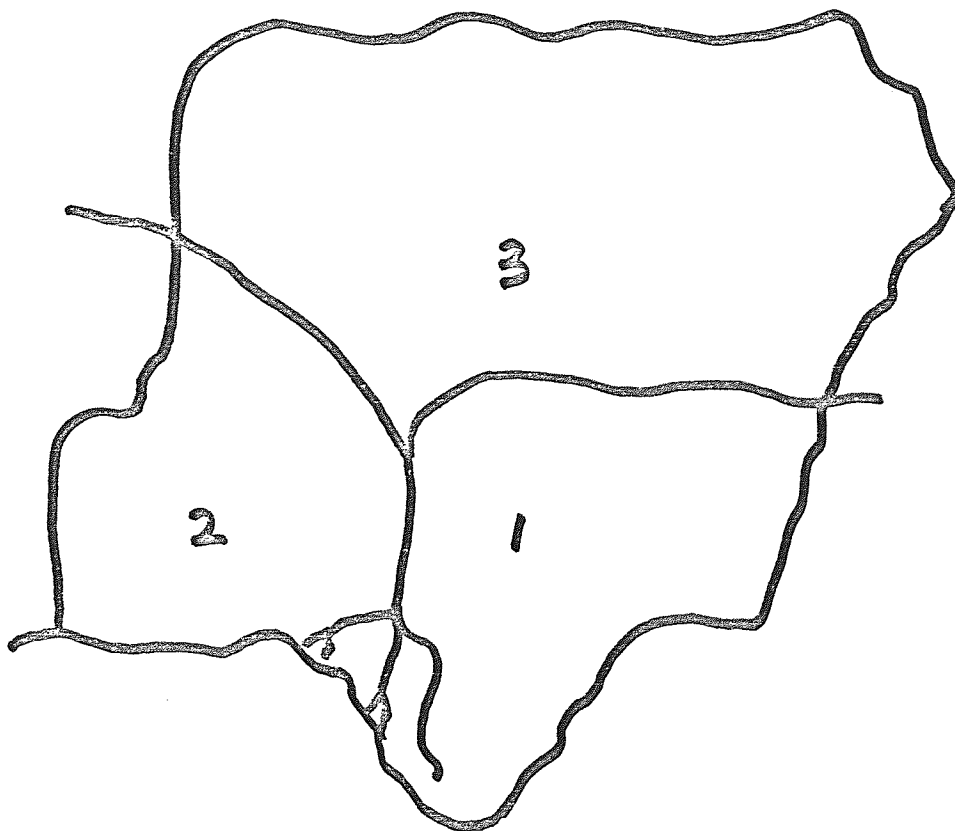
Area of Service	Ibo	Yoruba	Hausa
FP	1. Local health authorities use both stick and carrot to educate families to limit family size and care more for their babies.	Local health authorities have tended to over concentrate their FP campaigns in a few rural areas and almost totally ignoring the more remote and isolated communities.	Local health authorities tend to leave FP education programmes in the hands of State Health Boards which are quite remote from the people, hence their FP strategy does not reach the majority of local communities
	2. Information about FP is not easily or freely obtained due to lack of personnel, materials, and equipment. The government strategy for effective FP lacks financial commitment, as well as other resources.	A lot of pioneering efforts exist in some major cities where people are asked to go to obtain relevant information about FP but they seldomly do so. Personnel and finance to support the service is lacking and constitutes a barrier to information reaching people nearer their homes or community.	Some international bodies - WHO, UNICEF etc do a lot of basic studies on FP and demography and try to provide free services and information to the people so that they can learn to limit family size and improve the maternal child health. Finance does not constitute a major barrier but the ignorance of the people does.







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CHAPTER FIVE

TESTING THE RESEARCH HYPOTHESIS

A variety of methodological tools used to collect all the data through fieldwork process have been described in chapter three (i.e. Fieldwork Programme); whilst the Data Analysis in chapter four was done in two parts to ensure that all the data obtained with all these methodological tools (i.e. interviews, questionnaires, personal observation etc) have been analysed correctly. The aim of this chapter is to concentrate efforts in testing the research hypothesis as stated in 5.1 below.

5.1 OBJECTIVE

The objective of this chapter is to test the hypothesis: 'Primary Health Care can be effective if and only if health care delivery system matches the attitudes and expectations of the community'.

The strategies for testing this hypothesis have been developed and designed to consider if the health care delivery system matches the attitudes and expectations of the community based on the following criteria: The provision of appropriate and effective (PHC) services which are sensitive to the needs of rural Nigerians; the adoption of a policy for such provision, taking account of the differences between the Ibo, Yoruba and Hausa communities in culture, language, religion and in the uptake of the available health services as shown in 5.3 below etc.

These strategies have been developed and used to test (PHC) effectiveness in the three rural communities of study, to gauge if matching exists between the health care delivery systems and the expectations, attitudes and the customs of the village people.

5.2 CHANGE OF CIRCUMSTANCE

The number of villages for testing the research hypothesis stated above was reduced from four to three for a number of reasons:

1. There was a considerable delay in securing official approval from Local Health Authorities, Local Governments and rural communities thought to be feasible for field surveys in Nigeria.
2. There were serious political problems in Nigeria within and during fieldwork periods following, for example, the August 1985 Military Coup and counter-coups, which delayed correspondence, disrupted some fieldwork programmes and so on.
3. The (WHO) Research Grant for the research investigation took over three years before its final approval whilst the release of the amount approved is still tied up with bureaucracy.
4. There were problems which surround the clearance of research documents (e.g. the questionnaires etc) with the Nigerian Airport/Government authorities. Permission was needed to take them into the country to avoid being at any risk or being penalised for carrying them.

5. The research programme has exceeded the university's normal three-year period during which the research project should have been completed.

5.3 STRATEGIES FOR TESTING HYPOTHESIS

The strategies for testing hypothesis were designed to consider if the health care delivery system matches the attitudes and expectations of the community based on the following criteria:

1. The provision of appropriate health care services that are sensitive to the needs of the village people in the three rural communities (i.e. coverage, effectiveness, and quality of services)
2. The adoption of a policy for the provision of such appropriate health care services, taking account of the differences between Ibo, Yoruba and Hausa in culture, language, religion and in the uptake of the available health services in their locality.
3. The strengths, contribution and community involvement in PHC activities.
4. Planning and future provision of services for rural communities.
5. PHC manpower levels in the 3 communities.
6. Health facilities available to the community.

5.4 TESTING PHC EFFECTIVENESS IN THE 3 COMMUNITIES BASED ON STRATEGIES 5.3

Strategy:

- a. The provision of appropriate health care services that are sensitive to the needs of village people in the three rural communities (i.e. coverage, effectiveness and quality of services)
(1)
- b. The adoption of a policy for the provision of such appropriate health care services, taking account of the differences between Ibo, Yoruba and Hausa in culture, language, religion and in the uptake of available health services in their locality (2)
- c. The community strength, contribution and involvement in PHC activities (3)
- d. Planning and future provision of services for rural communities (4)
- e. PHC manpower levels in the three communities (5)
- f. Health facilities available to the community (6)

Rural Community	Strategy	Constraints	Solution(s)	Findings/Results	General Remarks
IBO	1	a. Inadequate training of Health Workers b. Inaccessibility of services to people - far distance and high costs of services c. Poor quality of services d. Insufficient drugs, medicines etc e. Lack of qualified staff at health centres/ dispensaries f. Poor standard of supervision of services at first level facilities. g. Management problems - planning, decision making etc.	Improve quality and quantity of service with special attention paid to a - f	Primary health care services are not obtained at a time the people require them, at a cost they can pay and in a manner acceptable to them	The assumptions that the understanding of health professionals about the people's needs is proved to be incorrect. The views of health needs held by health professionals and by the people are not identical
YORUBA HAUSA					
IBO	2	a. Tribal sectionalism and hatred b. Cultural differences - tradition, religion, language etc. c. Illiteracy d. Superstition e. Influence of traditional medical systems f. Fragmentation of governments - local, state etc	1. Decentralise PHC activities to accommodate cultural differences but with good central system of supervision of quality and standard of services 2. Educate people (Ibo, Yoruba, & Hausa) to learn to interact and mix with others outside their ethnic origin 3. Improve community relations with Local Health Authorities, health workers etc.	PHC services are patchy and lack continuity, co-ordination	Massive public education campaign to make all Nigerians learn to co-operate, and tolerate one another and avoid tribal confrontation, discrimination etc. Regional, provincial and community inter-transfers of health workers may be encouraged to fight tribal differences and improve service efficiency
YORUBA HAUSA					

IBO YORUBA HAUSA	3	a. Villager's suspicion of almost every government's intentions	Both governments and health authorities in Nigeria should:	The village people do not involve themselves actively in PHC activities because there are no government incentives for them to do so	Local health authorities, local government and state government should induce and make people be interested in PHC activities by financing road improvements, market facilities, good housing, rural development projects, agricultural and fertiliser inputs, general hygiene and sanitation improvements. In addition the socio-economic status of rural communities should be improved to reduce/eliminate poverty, create jobs and improve living standard of people.
		b. People's worry and constant fear of burden of high taxation	1. Recognise the strength and resources the people have that can be beneficial		
		c. Poverty	2. Respect and understand the social organisations and traditional institutions of the people		
		d. Lack of social services and social amenities in the communities			
		e. No real signs of community and rural development programmes	3. Give people hope for the future by creating opportunities for jobs, improving housing facilities, agricultural development etc.		

IBO YORUBA HAUSA	4	d. Nigerian governments stick to planning rural health service provisions from the centre with planners who have little or no experience and/or knowledge about rural community social organisation, culture, beliefs and interests	1. Train PHC planners to have first hand knowledge about the culture of the village people	Planning systems in PHC for these communities lack qualified planners and personnel with good understanding of village people, their health needs, their community and individual problems, their social organisation and culture	The Nigerian planners for PHC services are mainly people trained in the Western countries who have no real knowledge about the problems of village people in Nigeria. These planners do not plan services from the real situation but do so by remote control planning strategy which often fail to solve PHC problems inherent at the operations level i.e. the rural community.
		b. Most of Nigerian government planners have no real understanding of village people's health needs and their socio-economic problems	2. Train PHC planners within the rural settings in Nigeria		
		c. Planning PHC services for rural communities by remote control as it is done in Nigeria does not improve PHC effectiveness	3. Encourage rural community to be involved actively in PHC activities including planning and decision-making activities etc.		
		4. PHC planners should move away from the conventional method of NHS planning to an ideal PHC planning system that is			

culture oriented

- d. Lack of health information and epidemiological statistics from the rural areas restricts planning efficiency
- e. Duplication of services occur at different levels of PHC organisation due to incomprehensive communication lines at all levels.

IBO	5	1. Lack of qualified staff	a. Increase motivational training for all health workers	PHC manpower levels in the 3 communities are very low. This is partly because of lack of funds, inadequate training programmes, staff turnover etc and partly due to salaries of staff; improve working conditions of staff; give special incentives to attract people into rural health service delivery
YORUBA		2. Low wages and salaries of health workers		
HAUSA		3. Lack of training for staff	b. Reduce individual workers case load	Nigeria provide funds to finance training programmes, wages and salaries of staff; improve working conditions of staff; give special incentives to attract people into rural health service delivery
		4. Many workers are unclear about their jobs		
		5. Inadequate job training	c. Increase extent, purpose and quality of supervision	
		6. No regular supervision schedules	d. Job description for all staff	
		7. No fixed programme of refresher training	e. Formulate supervising schedules and procedures etc)	
		8. Overloading of workers case loads	f. Improve training of supervising staff	
			g. Staff to be increased	
			h. Regular retraining and refresher courses etc.	

6	JBO YORUBA HAUSA	1. Supply shortages - drugs, equipment etc	a. Provide money to expand clinic facilities	Government Health services still have low geographic accessibility, extremely limited outreach facilities, and as a consequence low use.	Community awareness and use of health facilities and services is low. The government strategy to remedy this is not in full force. Additional health facilities as supplements may be necessary e.g. by studying feasibility of utilising traditional medical facilities already available in the village.
		2. Extremely limited health facilities	b. Increase supplies		
		3. Low geographic accessibility of health facilities	c. Review policy on supplies and supply distribution		
		4. Limited number of cold storage facilities for vaccines at health centres and dispensaries	d. Expand cold storage facilities at health centres		
		5. Lack of sanitary facilities and water supply facilities at health units and clinics	e. Consolidate distribution network to improve redistribution		

With reference to 2 above, a policy should be designed which allows agencies of community government in Nigeria, such as local authorities and health authorities some free hands in making decisions about what services to provide, how to provide them, and how they will be allocated. These agencies should have a vital role in determining the quality and effectiveness of PHC services in their respective rural communities. This is particularly so, as there is growing recognition that the problems experienced in particular local communities (Ibo, Yoruba and Hausa) are often interrelated.

A policy directed to co-ordinate response to problems which cross agency boundaries may help to solve problems of fragmentation of government, remote and isolated rural communities etc. Important choices have to be made through effective and efficient planning programmes about how best to use the health and rural development resources available in meeting local needs and problems in rural Nigeria. Furthermore, efficient policy is required to improve rural sector economy; improve the perceived decrease in quality and quantity of basic health care services; and to remedy deficient social services which have highlighted a sense of dissatisfaction with, and disaffection from the village people.

5.4.1 Patients' Interviews

Surveys done of patients' opinions (N = 210):

Three major surveys have been carried out in the three rural communities to gauge out-patient's opinions about (PHC) effectiveness in their respective health centre and dispensaries. About 74 percent patients' views show that they were very dissatisfied (top of 5 grades of answer) with the

(PHC) services they were receiving at their respective health centres or dispensaries, when asked: "Have you found health centre/dispensary satisfactory in its care of the patients?" The proportion so displeased rose in all the three communities as shown in Table 8b of chapter four.

Other findings of the three surveys:

- (i) Patients mentioned bad manners and bad language of health workers, who are often accused also of having unsympathetic attitudes towards the suffering patients.
- (ii) About 95 percent of comments on "medical care" were unfavourable and respondents stress that medical care in their local communities needed improvement.
- (iii) There was high satisfaction in community and family planning nursing care - yet many criticisms of many other para-medics were levelled especially against the medical records clerks, the receptionists, dispensers etc.
- (iv) Most frequent criticisms were made to secure:
 - 1. improved relationships between patients and health workers
 - 2. More nurses and (PHWs)
 - 3. Better and more varied basic drugs
 - 4. Reduction of boredom at the out-patient departments and clinics e.g. by shorter waiting time, radio health education programmes, replaying tape recorded health education programmes etc.

Other criticisms include:

- (v) Understaffing/overwork at health centres/dispensaries.
- (vi) Lack of information of patients' illness and treatment.
- (vii) Authoritarian attitudes of some doctors to patients.
- (viii) Inadequate communication channels between patients and health workers.
- ix) Maternity patients were especially dissatisfied, perhaps because they are not really ill. About 60 percent of them (N = 75) complained of being left alone for sometime while in labour; they also levelled criticisms of lack of advice and information, of inhumanity in some nurses; of lack of privacy etc.
- x) Patients' expectations are wide ranging, for example:
 - 1. Good medical care - correct diagnosis; most effective treatment; information and reassurance about illness and prognosis; shortest possible waiting-time and shortest possible stay away from home; family and job; easier access to health services, facilities etc.
 - 2. Good nursing care - technical, kindness, cheerfulness etc.
 - 3. Good out-patient amenities - library, sanitary facilities etc.

Some further factors:

An initial step towards making PHC effective in these rural communities might well be to remedy the criticisms given above, but other factors also need consideration, although unknown to or imperfectly understood by the patients interviewed, I have to make reference to the following:

Good medical care:

1. The patient cannot, as a rule, assess the quality of medical care given. Only a doctor's professional colleagues can do this: and it would probably not be acceptable for "administrative doctors" as distinct from clinicians, to be given the job. Should not each Nigerian health centre senior medical staff carry out at intervals a "medical audit" on the clinical work done? The quality of the medical care being given is then checked - the shortcomings assessed - and remedy can be arranged.
2. More directly within the PHC Management/Administrators' powers. They must ensure medical staff a welfare, as well as other staff to encourage them to give of their best:
 - . Can overwork be relieved at all levels?
 - . Induction both courteous and efficient
 - . Exit interview
 - . Living conditions, off-duty, married quarters etc
 - . Regular inquiry about welfare and offers of help etc.

to show that the management and administrators do care for all staff.

3. Administrators must regularly check for: delays in out-patients being given first appointments; out-patient waiting too long; clinics becoming overcrowded etc.
4. Management should provide funds for proto-type training for senior and middle managers, para-medical and professional studies, auxiliary training to bring improvement in PHC services.

Good Nursing Care:

Many Health Centres and dispensary authorities can do little to help recruit more nurses, primary health workers etc - but much might be done to help retain some of the student nurses who resign during their 3 years training, and to give nurses more time in which to nurse their patients more efficiently. There are other important issues -

1. Work study of out-patient clinics may be necessary.
2. Laymen can check that the out-patient clerical procedures are the absolute minimum needed and carried out in the most labour-saving way e.g. topping up routine.
3. Is out-patient departmental work allotted logically among grades of staff. This may call for the help of the Operational Research scientists. So much can be done by nursing auxiliaries, primary health workers, administrators etc.

4. It is important to realise the need to check efficacy of amenities for nurses at intervals - library books become soiled, sanitary facilities and sanitation inadequacy etc.

Therefore the responses from the patients interviewed in these three rural communities show that PHC systems in their communities are ineffective.

5.5 PROPOSALS FOR DEVELOPMENT AND IMPLEMENTATION OF STRATEGIES

1. Develop priorities identified within the strategies outlined.
2. Develop appropriate programmes for progressing these priorities for example, time-tabled for inclusion in the plans for PHC:
 - . State Ministry of Health
 - . Local Health Authorities
 - . Village Health Committees
 - . Women social organisations etc.
3. Ensure implementation of the programmes and monitor and evaluate these programmes.

5.6 HEALTH CARE PERSONNEL FOR IMPLEMENTATION OF PROGRAMMES

This would require setting up Action group or Steering Group made up of different categories of health workers and personnel from health-related sectors who will implement programmes. They may include:

- . PHC Teams

- Personnel from Ministries of Agriculture, Education, Rural Development etc.
- Outside Consultants - WHO, UNICEF etc.
- PHC Research officers/fellows/assistants
- Community Representatives - Community leaders etc
- Health Administrators from Ministries of Health etc.

It would be necessary to specify the role each participant should play in the implementation programme, which amongst others must include:

- supervision of PHC activities
- prototype training for middle managers
- Re-orientation of existing health workers for them to adapt to new changes
- Health education programmes at health centres/dispensaries, community etc.
- Liaison with community/village leaders; Traditional Birth attendants; local health authorities; rural hospital senior staff etc
- Regular contacts with Ministry of Health senior officers to:
 - approve financial budgets and allocations to PHC services
 - supervise standard and quality of PHC services
 - co-ordinate PHC activities
 - Develop Research and development programmes in PHC etc.

5.7 WORK PLANS FOR IMPLEMENTATION OF STRATEGIES AND TO MONITOR AND EVALUATE THESE PROGRAMMES

The work plans for implementation, monitoring and evaluation of programmes should embrace the following activities:

1. Build up a network of communications between (PHC) Personnel and the Ibo, Yoruba and Hausa local communities, community-leaders, village health councils, state Ministry of Health to facilitate health care needs of the village people.
2. Assess the appropriateness and accessibility of available health services being provided in the rural areas.
3. Provide information about the relevance of PHC programmes through, for example,
 - Health Education
 - Publication of materials (PHC) in Ibo, Yoruba and Hausa languages
 - Radio broadcasting and radio bulletin.
4. Develop and enlist peoples interests for them to be actively involved in PHC programmes.
5. Develop and implement appropriate training programmes for PHC effectiveness

6. Provide financial and material resources
7. Promote, preserve and understand the Ibo, Yoruba and Hausa cultural identities, social organisations and traditional establishments.
8. Identify specific areas of need for action to ensure concentration of energy, resources and real improvement of services.

5.8 GENERAL FINDINGS AND CONCLUSIONS OF HYPOTHESIS TESTING

5.8.1 Summary of major findings

The general findings from testing the hypothesis show that people have low opinions, negative attitudes and high expectations of the PHC systems in the rural communities. The serious nature of people's concern about PHC ineffectiveness in their rural areas means that alternative ways of implementing programmes to match people's expectations are being urgently asked for by the people. Based on this and other findings (as listed below), a number of conclusions have been reached which are stated below. Following these conclusions, a number of ways to implement PHC programmes in the three rural communities to match the expectations, attitudes and customs of the village people in rural Nigeria as necessary part of recommendations to improve PHC effectiveness have been suggested.

1. NUTRITION:

It is difficult to fully summarise the state of nutrition in the study communities as some of these nutritional zones co-exist and are experienced by the people living in the same village. However observational findings have tended to confirm that:

- a. Low calcium intake in these communities does not lead to clinical signs of calcium deficiency and anaemia due to iron deficiency: a claim that is also contained in the report by the International Bank (1954) Nigeria.
- b. The study areas show broadly speaking two different nutritional differences. In the north (Hausa), the main foodstuffs are guinea corn, millet, cowpeas, groundnuts and beans, all of which are rich in protein. In the South (Ibo and Yoruba), most crops provide the only staple diets from yam and cassava mainly. These root crops have only a small amount of protein content.
- c. In some parts of north (Hausa), too little of Vitamin A causes night blindness and eye troubles generally and that of Vitamin C leads to minor degrees of scurvy. Deficiencies in both vitamins reduces resistance to infection. The Ministry of Agriculture in Kaduna State is persuading local farmers and peasants in these rural communities to grow more green leafy vegetables - spinach, sorrell, Okro, and more fruits - mango, guava etc. However, it has been the opinion of the Federal Nutrition Specialist that clinical signs of Vitamin A deficiency are less common in the study area than they were ten years ago (Uchendu 1960).

d. In the South (Ibo and Yoruba), the rural communities of study present different picture, where it can be estimated that the overall intake of calories and proteins by both adult and young children is generally below a satisfactory level. The calorie deficiency reduces energy, and in these communities the people most affected are the pregnant women, nursing mothers and children.

e. In both north and south however, malnutrition occurs in all the study areas. It lowers physical and mental condition of children and nursing mothers, brought about mainly by faulty, careless or inadequate diet and bad nutritional habits.

However, it is also observed that in communities malnutrition problem does not necessarily mean that the people are starving. They sometimes have plenty to eat but feed themselves wrongly by taking wrong things.

f. There are some village people who are unable to obtain as much food as they would need because of poverty or other hardship. There are equally some village people who tend to eat enough food to satisfy their appetites and yet not be getting all the nourishment the body requires.

g. Clear signs of malnutrition are evident in all the communities as people show variety of symptoms, for example:

1. The skin is thin and dry and little or no fat is felt under it.
2. The hair is dry and pale.
3. The eyes are dull, show signs of damage.
4. The lips show cracks and sores.
5. The child is usually thin with swollen face, abdomen and feet.
6. The child is abnormally quiet and tired, lacking energy to play.
7. Diseases are caught easily and recovery tends to be slow and difficult.

h. The main causes of malnutrition in these communities include shortage of food, poverty and ignorance. Most of the villagers do not take costly but rich foods because they cannot afford to buy or produce them. Many people eat unsuitable food due to ignorance. Some people do not understand the nutritious value of some foods and the necessity to eat them.

i. Superstition plays part and contributes to malnutritional problems in these communities. There are many examples. The village people tend to be superstitious about some dietary habits which are known to be healthy: egg is regarded as white man's food etc.

j. Due to varying sizes and diversity of these communities themselves, there are natural exceptions to the above nutritional findings, for example:

1. The fisherman in the south receive an adequate intake of protein.
2. Children in both north and south tend not to receive a large enough share of the food available, especially the right type of food. In the north this retards growth and causes skinniness.
3. In the south, protein deficiency type of malnutrition is most common in children leading to a high mortality rate of children below the age of five. In the south also, the poor families rely mainly on starchy foods and suffer from protein deficiency and varying degrees of under and malnutrition.
4. The South tend to depend on the North for foodstuffs with a high protein content: guinea corn, millet, cow peas etc.
5. In both north and south, milk is absent from the diet of about 75 per cent of the population and Vitamin B₂ deficiency (Riboflavin) are sometimes observed.
The village people are unaware of dairy farm projects and milk production at such other places like Vom, Jos in Nigeria.

K. The main faults in diets of the communities include:

1. Monotony and lack of variety - the village people depend on a main staple such as cassava, plantain, yam, grains. Peasant farmers take little animal protein because they are costly.
2. Lack of food from animal sources - peasants keep poultry but many of them still regard eggs as white man's food.
3. Except for fishermen and people in the riverside areas, little fish is eaten.
4. Poverty, ignorance and superstition still prevent some village people from taking enough or the right types of protein with their foods.
5. Lack of fruits and fresh green vegetables which are the sources of minerals and vitamins.
6. Lack of animal fats.
7. Underfeeding contributes to malnutritional diseases.

2. WATER:

The common impurities observed in the drinking water in these communities are dangerous and have contributed to high incidence of guinea worm, diarrhoea, skin problems etc. - Almost all the rural

communities in the study areas draw their water from ponds, streams, shallow wells and other suspicious and dangerous contaminants. The villagers tend to wait until their state government water authorities provide a bore hole plant for rural water supply. This takes time as government resources and budgets for rural development in Nigeria is generally both minimal and disappointing. However, a few communities are now beginning to save themselves from the dangers of water borne diseases by improving the source of their water supply and measures they have so far taken in this direction include:

- a. Organising a health week or sanitation day which is compulsorily supervised by the Nigerian Military task force, during which streams are cleaned, deepened and sources protected from animals and careless village people - by round-fencing the stream-source.
- b. Pit latrines are provided at intervals along the road to the stream to avoid indiscriminate deposits of excreta which finds its way into the stream after the first rain.
- c. Flood control so that running water does not get into the stream during the rains.
- d. Enlisting the cooperation of the village chiefs, community leaders and councillors about the need to keep the streams clean.
- e. Educating the village people on health and sanitary good behaviours and practices and encouraging them to boil water for drinking in their homes.

3. SANITATION:

The general cleanliness in these communities is bad and this situation tends to spread diseases in people's homes and in the environment.

4. BASIC HEALTH CARE:

a) Women and children in the study rural areas share a disproportionate burden of deaths and illnesses.

b) A good number of health problems account for a major proportion of all infant' morbidity and mortality - malaria, measles, whooping cough, diarrhoea etc.

c) Rural communities in the study areas contain extensive network of both modern and traditional health services but the former has not achieved the expected acceptance of the people.

d) Lack of information is a more serious barrier to improved health than the limited availability of services in these rural communities.

e) Staffing. Despite almost universal dissatisfaction with, for example, staff/patient ratio which has enormous gap, some health centre staff (community nurses, and family planning auxiliaries) were judged to be providing good nursing care and nursing services at health centres and dispensaries. However, some

village people criticised attitudes and manners of a number of other health workers (dispensers, medical records personnel and receptionists) who very often use bad and abusive language.

- f) Drugs and Medicines. The majority of village people allege that they do not obtain medication, consultation, drugs and medicines in time because of corruption, lack of staff or because of untrained staff and absenteeism of health workers. These and other serious complaints headed the list of changes thought to be the most important and necessary in order to effect improvement in basic health care delivery systems in the three communities.
- g) Finance. Although the overwhelming number of those interviewed were critical of Nigerian governments for not providing sufficient funds for PHC services in their rural areas, they almost universally agreed that they would pay or be prepared to pay extra-tax to support and obtain improved and effective (PHC) services as shown in chapter four Table 10.
- h) Bribery and corruption is thought to cause great concerns to many villagers, especially the poorer ones, about which people focused their complaint and this is often a lightening conductor of their frustration with the health centre/dispensary systems.
- i) The health centre routine and health centre equipment are criticised too and have become matters of importance and irritation to local populations. Complaints are directed towards

delays/bureaucracy in obtaining effective treatment, basic and essential drugs, consultation and appointment procedures, longer waiting time at the out-patient departments and so on.

- j) People's involvement in PHC activities is clearly lacking as revealed in people's responses. The responses from both village people and patients who were interviewed during the field surveys clearly indicated that they wish to have a voice on the PHC management activities and not have information passed onto them like parents to children. Imposition of ideas from the top to the people alienates them from policy-making processes and acts as a barrier to their effective contribution to PHC programmes. The out-patients at health centres believe that patients involvement and participation in decision-making of matters that affect patients has not been addressed sufficiently as they would wish it to be.

The patients also felt strongly about the need to create an atmosphere whereby both the providers of the service and the consumers of the service can meet more regularly to exchange views about a range of subjects, for example, patients participation in PHC management; conditions at health centres; avenues for necessary improvements; procedures for patients' complaints etc.

- k) Health Professions (Doctors). About 74 percent of village people interviewed believe that Nigerian doctors who treat them at health centres and dispensaries attempt to impose Western

customs and traditions which are inappropriate and which cannot really be successfully adapted to Nigerian village social organisations. Despite good medicines and good intentions of the Nigerian doctors at health centres and dispensaries, the village people regard them with suspicion because their conducts (doctors) usually identify them as Western-oriented in their attitudes and manners.

- 1) Culture and Tradition. As evident from the general observation of people's attitudes to health and their illness behaviour, their customs, social and cultural aspirations, there are several cultural constraints/factors which can be perceived as barriers to effective PHC programmes. These other factors prevent the health care delivery system from being successfully matched with the attitudes and expectations of the people. The main cultural constraints amongst others include superstition, differences in religion, traditional medical systems, family social organisations of the Ibos, Yorubas and Hausas.

5.8.2 General Findings

(Observation): Bad management and lack of efficient management organisation have created some loopholes in the administration of PHC services in the three communities.

1. There is inadequate supervision, insufficient supplies, drugs, medicines and materials.

2. The present arrangement provides some form of supervision of the dispensaries. However in practice it was discovered that the supervision is totally inadequate.
3. There is certainly some element of discontent among the local health authorities' dispensary attendants and health centre staff because they are poorly paid as compared with state Ministries of Health counterparts, or the general and teaching hospital staff. In addition they have less attractive schemes of service, with no opportunity for promotion, and little incentive to motivate them.
4. As there is no proper organisation and coordination between the dispensary and health centres, the patient referral system does not operate properly. It is to the discretion of the dispensary assistant to decide when and how to refer his patient.
5. Almost all the dispensaries complain of inadequate supplies of drugs, equipment, maintenance supplies and other materials.

Referral System: There are a number of reasons why the referral system in health centres and dispensaries does not work or where it does, it is inefficient. These reasons include:

1. The State Ministries have no system of monitoring local health programmes through referral systems.
2. No contacts are made with patients to see that recommendations are followed once they leave health centres and dispensaries.

3. No policy for ongoing contact.
4. No collaborative planning with patients so that he or she knows who to contact for both assistance and advice or when to return for a follow-up care or what to do once he returns home.
5. No warning about side effects of a non-follow-up.
6. No coordination between the referrals and recipients.

HEALTH WORKERS CRITICISM OF MANAGEMENT

Some health workers have criticised management too for:

- a) its failure to develop PHC policies which are coherent and consistent with the overall PHC objectives in these communities.
- b) its bureaucracy and delays in paying their salaries and wages on time.
- c) its inability to motivate health workers (e.g. through promotion opportunities, good incentives, efficient training programmes, welfare schemes etc) which leads to low morale, rapid turnover and apathy of a good number of them.

The general conclusions from both interviews and general observation clearly reveal lack of Government/individual commitment to PHC development programmes; inadequate management procedures - decentralization and planning systems in PHC activities; Non-reorientation

of health workers; Health For All by the Year 2000 and its implications for the Nigerian PHC strategies.

Further strategies to improve the Nigerian PHC systems based on these general conclusions can be examined which form the basis for Chapter 6.

5.8.3 General Conclusions - Health Workers etc

HEALTH CENTRES AND DISPENSARIES (OBSERVATION):

1. HEALTH WORKERS:

1) Diagnosis:

- a. From personal observation diagnosis and treatment is not of adequate quality.
- b. Clinical examination is rarely carried out.
- c. Technical knowledge sometimes insufficient to deal with problems.
- d. No guidance concerning referral to health centres from dispensaries etc.
- e. Lack of clearly defined job descriptions.

- f. Insufficient supply of drugs, equipment, material etc.

2) Prevention:

- a. Preventive services are not regularly provided at first level contact.
- b. Sick people from distant areas are brought in for treatment only when seriously ill.
- c. The dispensary and health centres do not provide the much needed basic health services. They provide only a limited curative service and nothing on preventive and maternal and child health services.
- d. There are no qualified female staff at the dispensary to carry out the maternal and child health duties.

The manpower problems at these health centres and dispensaries can further be stated as follows:

- 1. The present staffing pattern and staff/task distribution is not fully adapted to cope with the health problems at the health centres, dispensaries and clinics.

2. Staffing pattern and staff/task distribution does not clearly:

- a) Establish the extent of over or under utilisation of the health centre staff or dispensary workers.
- b) Demonstrate appropriate delegation policies of the health centres: current staffing pattern, time available for direct care, observed technologies, objectives of management.
- c) Estimate the capacity of health centre and dispensaries, number of patients that can be seen at each if the most appropriate delegation policy is pursued.
- d) Allocate resources to direct care in line with treatment patterns.

3. The health centre system also suffers from problems related to staff commitment and morale:

- a) No opportunities for promotion and career advancement.
- b) Little or no financial incentives.
- c) Lack of training opportunities.

TWENTY

PART III

CHAPTER SIX

STRATEGIES FOR PRIMARY HEALTH CARE IMPROVEMENT IN NIGERIA

As stated in chapter 5.8.2 above (i.e. General Conclusions) this chapter is designed to explore general strategies that could be implemented at both government and individual levels in Nigeria to improve the Nigerian PHC systems and make them more effective.

These strategies include some alternative ways of implementing PHC programmes to match people's attitudes and expectations in the rural communities; strategies designed to strengthen and improve the health care delivery systems to make PHC systems effective; strategies for efficient PHC management procedures etc.

As part of these strategies, some recommendations have been made to both government and individual for implementation which could improve PHC effectiveness in rural Nigeria.

6.1 ALTERNATIVE WAYS TO IMPLEMENT PRIMARY HEALTH CARE DELIVERY SYSTEM TO MATCH THE EXPECTATIONS, ATTITUDES AND CUSTOMS OF THE VILLAGE PEOPLE

Based on the conclusions that have been made in Chapter Five which indicate that the (PHC) systems in the three rural communities are ineffective, there are a number of alternative ways that can be suggested for implementing (PHC) programmes in rural Nigeria. These alternative

ways may match the expectations, attitudes and customs of the village people in the health care delivery system.

The following are some of the alternative ways suggested to be important:

1. If (PHC) is to find a firm base in the rural Nigerian and become effective under the existing conditions (economic, political, social etc), (PHC) role must be defined according to Nigerian village concepts and practices.
2. PHC system should provide efficient services at reasonable charges, rather than being perceived as a second-class medical system designed to exploit the poor villagers.
3. Basic and essential drugs, treatment and other services should match the health needs of rural populations in terms of quality, quantity and appropriateness.
4. The local health authorities in Nigeria should commit themselves to providing essential social services and community services to the people.
5. PHC systems should be established within the village and close to medical needs of the people.
6. Less medical in-put should be put into curative medicine and more to preventive services in the rural Nigeria.

7. The social organisations and institutions of the village Nigerians should be recognised, respected and accepted as necessary and important agents to implementing PHC services effectively.
8. Responsible and discrete handling of village people's complaints (and criticisms) of quality and quantity of services should be one of the greatest concerns of PHC management and PHC authorities in Nigeria.
9. The role of State Ministries of Health must be radically reviewed (e.g.), the re-organisation of certain sections of the ministry may be necessary in order to
 - a) bring Ministry nearer to the people, rather than being too remote from them;
 - b) review the functions of public health division
 - c) reappraise financial budgets and approval from ministries to local health authorities;
 - d) delegate responsibilities/accountability and establish communication lines etc.
10. Many primary health workers and health auxiliaries should be trained to serve rural communities with more emphasis placed on preventive health services training.
11. Community involvement should be actively encouraged and seen as pre-requisite to successful implementation of PHC activities in the rural areas.

12. The general attitudes and relationships between health workers and community/patients should be improved with good understandings, courtesy and sympathetic attitudes to the conditions of people in greatest health needs being given priority.
13. Nearness of health facilities is very important when accessibility of service to the people is considered. The average distance of about 3-5 miles may be ideal.
14. Geographical re-location of boundaries of scattered and isolated rural communities may be undertaken to make it easier for them to have health clinics, mobile clinics and health services.

6.2 THE HEALTH CARE PROFESSIONALS' ROLE AND FUNCTIONS TO IMPROVE PHC EFFECTIVENESS IN RURAL NIGERIA

Basic health care provision in Nigeria can be improved if certain specific steps are adopted by the Health Care Delivery Professions to make the (PHC) more effective, for example:

HEALTH WORKERS:

1. improved treatment methods (e.g.)
 - a) correct diagnosis, most effective treatment, sufficient information and re-assurance about illness and prognosis procedures, good nursing care.

- b) preventative measures directed against smoking, alcohol consumption, unwanted pregnancies etc.

2. preventive strategies:

- a) identifying modes of transmission of infectious diseases so that spread can be interrupted.
- b) behavioural studies into personal hygiene and sanitation to identify ways to limit transmission.
- c) importance of vaccines in preventing some diseases
- d) methods of promoting breastfeeding for young nursing mothers, eating well during pregnancy, child birth etc.

3. Better distribution and use of drugs in health centres, clinics, dispensaries etc.

4. More and regular home visits by health workers : doctors, community nurses, primary health-workers, sanitary workers etc.

5. Evaluation of the efficacy of any new vaccine and the best way to deliver and store them at health centres and dispensaries.

6. Communication strategies:

- a) More understanding of traditional beliefs of the village people and practices about causes and treatment of certain diseases traditionally so that health education campaigns can be designed in a way that may be culturally more acceptable to the people.

- b) Effective ways of reaching village communities with appropriate information necessary for health improvement of all.
- c) Ways of promoting and improving training techniques for all health-workers.
- d) Methods of education which can be effective for personal hygiene practices.

7. Motivating health workers with decent pay, incentives, salaries, remuneration, promotion etc to:

- a) accomplish targets set for them in time
- b) accept worker evaluation process for work efficiency
- c) allow participation of supervisors in practical training of field workers
- d) practise regular reporting of activities, successes and failures.
- e) improve performance through a feedback information system.
- f) attend reorientation courses in (PHC) to acquire necessary skills and experience.

8. Accessibility of health workers to community members/patients:

- a) being available at times the health workers are most needed in the community and at other times
- b) adequate contact between the families and field health workers

- c) regular home visits, including visits at worst weather conditions which disrupt visiting, emergencies - calls etc.
- d) Nearness of health workers residential homes to patients'.

The environmental health worker should pay more attention to health education in his day-to-day activities. A lot can be achieved by encouraging community projects such as clean-up campaign, provision of wells, incinerator etc. which can be done by e.g. seeking the cooperation of rural development agencies in Nigeria.

6.3 EFFICIENT MANAGEMENT PROCEDURES TO SUPPORT PHC EFFECTIVENESS

The efficiency and effectiveness of Primary Health Care System in Nigeria may require that a permanent, systematic and efficient managerial process be established. This would demand organisational arrangements and framework which lead to efficiency in leadership, supervision, communications, team work, motivation, decentralization of decision-making and planning greater political commitment, innovative approaches to upward health planning, appropriate reorientation of health workers in Primary Health Care activities etc.

6.3.1 Political Commitment

The governments of Nigeria still need to be sufficiently committed politically to all the necessary primary health care programmes being initiated and developed and this they can do in terms of : resource allocation; a declaration of high-level commitment; degree of equity of distribution of resources; degree of community involvements; establishing effective organisational framework and managerial process at all levels of the government, and promulgating necessary legislations to promote and support the system more efficiently.

A declaration of Nigerian governments (Federal or State) commitment to Primary Health Care development may constitute, for example, a policy statement in favour of primary health care system from the highest level of authority, such as the Head of State or from his Supreme Military Council with some Associate Top Civil Servants, and senior politicians of different political parties with Civil Government administration experience. Any policy statement of this nature from eminent and experienced and interested Nigerians may go further to spell out at budget level in specific terms, the financial resource allocation to be included under Primary Health Care package as distinct from all the various aspects of Health Sector. Equally, the degree of equity of distribution needs to be emphasised in terms of, for example, proportion and geographical distribution of rural communities that do not have reasonable access to clean water basic health facilities, basic health care coverage etc. The degree of equity would also be considered from adequate distribution of financial and manpower resources : distribution per capital expenditure on health between geographical areas, between rural areas and urban areas;

the proportion of total health resources going to primary health care by districts; the ratios of health workers (doctors, nurses, primary health workers, supervisors etc) to populations of different localities etc.

Political commitment to primary health care development in Nigeria must also reflect to the way decisions are being taken at the centre in which case, there has to be a means created to allow communities active involvement in both decision-making and planning and which creates effective mechanisms for the village people to express demands and needs through local organisations.

The development and use of an appropriate managerial process should be part of political commitment of Nigerian governments' to primary health care and should include such programmes like monitoring and evaluation which can be done by or at Ministries of Health, teaching hospitals or some health-related organisations to assess, for example, if there is effective communication between different organisational levels and different departments within ministries of Health and other relevant sectors; whether mechanisms exist to facilitate this communication and for some joint policy and programming of activities (districts, national health committees etc)., whether all technical divisions in a Ministry of Health participate in joint management of primary health care programmes to ensure integrated service., whether Nigerian universities, medical schools, research institutes are sufficiently involved in research and service functions relevant to development programmes in primary health care.

When introducing necessary health reforms, the Nigerian government may also be inclined to use legislation to define, for example, the rights and

obligations of people concerning their health; to protect people from environmental pollution and hazards; assist rural communities to develop and manage their health and social services more effectively. By-laws may be passed at local government level to improve public health standards, sanitary conditions, regulate latrine construction schemes in people's homes, promote voluntary services etc.

Political commitment should not however, be restricted to government(s) of the day in Nigeria alone, but must be extended by other non-government efforts to ensure the support of public figures and bodies as appropriate, including political parties, religious and civil leaders, trade unions etc. Popular support should be mobilized by involving individuals and families in their own health care in various technical, supportive and financial activities involved in primary health care development.

6.3.2 Decentralization of Decision-Making

The importance of a political decentralization, administrative decentralization and planning decentralization of Nigerian Primary Health Care activities has to be recognised to make the system effective. The concentration of decision-making powers at the federal level should be diminished so that there can be no direct way by which the Federal Government can control or exercise oversight over the activities of state or local government within their own spheres of decision-making powers in primary health care programmes, although it may be able to do so by the virtue of its much greater financial resources and the consequent possibility of giving grants on condition that the state or local government (local authorities) perform certain functions in the required ways to meet

Federal Government's health requirements. However, given the need for decentralization of decision-making in the Nigerian Primary Health Care System, there has to be a satisfactory process which allows the local health authorities to make decisions at points as near as possible to where the actions and primary health activities are taking place in the rural communities. In this way the process can be able to utilise local and immediate knowledge, labour, materials available in many Nigerian rural communities and make for timely action. Decentralization of authority should be necessary in view of geographic dispersion of the several scattered communities of Nigeria, which are sometimes inaccessible or isolated, especially in the riverine or mountainous areas. There are other reasons for decentralised system apart from diminishing the concentration of decision-making at the federal capital. The diversity of natural conditions in Nigeria, the economic potential, social and cultural variations, values etc demand flexibility in the mechanisms to achieve nationally agreed primary health care goals and adaptability in the definition of those goals themselves. Assuming that the federal authorities accept and approve decentralism, it may be possible to promote the ideas in Nigeria that specific advances of specific rural communities in primary health care development can be adopted as models to encourage similar initiatives elsewhere in the country, in which case, such network can be used to exchange information which may be used to assess the potential benefits of inter-community cooperative efforts and exchange of ideas. It may be imaginable that such exchanges could cover some practical aspects also associated with development projects, for example, adapting technology to meet local conditions, initiating small pilot efforts in health and food production, initiating prototype training packages, establishing community organisations to control and monitor some local activities etc.

Decentralization can refer to the devolution of political authority or it can refer to delegation of executive authority, the measure of freedom that exists in the implementation of specific tasks that must be carried out to fulfil agreed policies and programmes or it can refer to a planning process in which targets are set, activities planned and resources allocated by those who know the local conditions much better than anybody else, with little or no consultation from the centre.

The importance of decentralization of decision-making in the Nigerian primary health care system has to be understood in terms of :

- a) political decentralization for appropriate devolution of authority in which the operation of subnational government structures actually decide on policies and plans and their implementation at State or community levels ;
- b) administrative decentralization which delegates authority and gives a measure of freedom in the implementation of specific tasks that must be carried out to fulfill agreed policies and programmes; and
- c) decentralization of planning in which planning process is undertaken at community/village level by setting of targets, planning of activities and allocating resources with much consultation with those who know the local conditions intimately, for example, village health committees, women's association; primary health workers, community and church leaders, local

voluntary organisations, traditional healers and traditional birth attendants.

Disadvantages : There are some arguments that may be put forward against a decentralised system in Nigeria, for example, decentralized authorities may become too independent of the Nigerian national health system and may tend to see primary health care as a separate health service existing independently. Should this happen, there might be a tendency for local health authorities in Nigeria, for example, to work against the policies of the state or federal Health Authorities or both.

The second disadvantage could be that at the operations level, because of lack of expertise and qualified personnel at that level to accomplish certain tasks, decisions may be the result of compromise since power and authority are often fuzzy and diffused. This then may lead inevitably to bureaucracy in which decisions are taken too slowly and represent the lowest common denominator of area(s) of possible agreement. Authority and power at mentioned above can be distinguished, authority being the right to issue valid instructions which others must follow, while power implies that the person(s) holding it has the ability to coerce someone into doing something that the latter does not want to do.

There are other problems with a decentralised system : decentralization may result or lead to heavy overhead costs since the local health authorities/local governments as well as state governments in Nigeria may duplicate some of the work done at Federal level, rendering Primary Health Care ineffective and inefficient. Furthermore, the decentralized system may have disadvantages for some health workers (eg Primary health

workers and the members of their team) if they feel that their career opportunities are limited to rural communities only and that there are less incentives and promotion opportunities for them in comparison with their other contemporaries working in the city general or teaching hospitals, Ministries of Health etc.

The best suggestions that can be put forward for overcoming the above disadvantages may include working out a clear specification of objectives and management structure, detailing job descriptions of every employee and ensuring that these are understood by all concerned.

The advantages of decentralization can only be achieved if - a) the echelons at the centre genuinely delegate the requisite authority and responsibility; b) those responsible for managing the activities at grassroot level do not exceed the proper limits of their discretion; c) decentralization should be supported by central guidance in reaching decisions involving, for example, resource allocation, and setting of the overall policies with mechanisms to ensure that those at the peripherals operate within the limits of official framework, without necessary encroaching directly on the activities done at the central/state levels.

6.3.3 Planning

- a. PRIMARY HEALTH/HEALTH PLANNING
- b. RURAL DEVELOPMENT PLANNING

a. PRIMARY HEALTH/HEALTH PLANNING

A good system of planning for primary health care and rural development to improve quality of life of majority of Nigerians is most desirable in Nigerian rural areas. Health planning system in Nigeria is still a self-contained exercise in which only the medical profession seem to be the people eligible to focus on health service programming, which has little or no bearing with development planning for primary health care and rural communities.

The Nigerian national health planning system begins by identifying priority health problems and then, in the context of the general resource situation, programmes health care activities to resolve them. These programmes are translated into costs, which are then considered in the light of the resources that appear to be available at the time. Very often, the addition of the costs of all the programmes turns out to exceed the available resources, either during the planning stage or during the phases of implementation. There is then the familiar occurrence of programmes having to be at standstill or some cut-backs for shortage of funds being introduced as financial stringencies. There are two main problems with this method of conventional programming namely:

- 1) it often fails to provide an adequate framework for specifically planning resource provision, the material basis for health programmes;
- 2) and more regrettably, it fails to provide an adequate planning framework for ensuring the provision of resources for primary health care as a whole, or equitable distribution of resources between different health development programmes.

Both Health Planning and Rural Development Planning systems should aim at even development, especially in the less developed communities of Nigeria. There has to be overall guidelines for health policy and for primary health care in particular which must equalize health services between the rural communities and states; minimise building more teaching and general hospitals in the urban areas only. Health policies for even development should favour allocation of most of the health development expenditure to primary health care and restricting developments in these urban teaching hospitals to absolutely essential items within the overall plan for an integrated Nigerian health system.

A national health plan should secure a guide for political decisions in line with Nigeria's general development strategy, which shows genuine concern for equitable distribution of improved services for all the populations. There is also the need to build into development planning systems in Nigeria an efficient inter-sectoral links between health and rural development planners to achieve a more balanced and effective development programmes, with additional support coming from the technical decision-makers dealing with, for example, agriculture, public works, education, housing etc.

The distribution of available resources to achieve even development in primary health care and rural development may be based upon, or determined by certain criteria; for example, by considering for example, the socio-cultural, political and economic conditions and circumstances that prevail in different rural communities: by considering extent of population density and health coverage; rural child mortality trends; life expectancy; malnutrition and under-nutrition among children: ratio of health personnel to a given population etc. These criteria may help the government to understand the extent and degree of social problems and make grants available to solve them and shift more resources to develop and improve both new and existing services with financial allocations being weighted in favour of the disadvantaged groups and communities in Nigerian society as a whole.

Furthermore primary health care planning system in Nigeria should be health-need oriented as this can be a precondition for successful primary health activities programming, despite the fact that needs of people may always remain infinite and resources available to meet them limited.

b. RURAL DEVELOPMENT PLANNING

Rural development planning system in Nigeria must be concerned with three major objectives, namely:

- i the meeting of basic human needs
- ii providing power to the poor
- iii maximising individual human growth and development.

These objectives if adequately accomplished can represent true development and satisfy the basic needs of people - socially productive work, reasonable income and the fulfillment of basic individual and collective necessities : food, shelter, health, security etc. The satisfaction of these basic needs does not itself constitute development, rather development implies that with the satisfaction of these basic needs people would progressively achieve control over the social and material conditions which determine their life, work and environment, and in particular, over the processes of production, distribution and consumption in their community. Rachnema (1975) stressed that development is a process of liberation and a process of putting an end to all forms of dependence, maintaining that to grow is to grow self-reliant, a gradual movement upwards, free from those influences which can only distort and retard it.

Markley (1975) believes that real development "entails an ecological ethic, emphasizing the total community of life as well as the oneness of the human race; involves a self-realization ethic, placing the highest value on development of the individual; conveys a logistic sense of perspective of life; balances and co-ordinates satisfaction along many dimensions rather than over-emphasizing those associated with status and consumptions be experimental and open-ended, rather than ideologically dogmatic".

Rural development planning in Nigeria should however be based upon effective organisation of a flexible and sensitive structure and network of communications between government, government workers and communities to enhance mutual understanding of the importance of rural development in the country, and the need for joint action by all

concerned. Any joint action may be considered from a combination of factors such as social, political, cultural, environmental constraints that can only be tackled by collective action before programmes can be implemented. Promotion of mutual understanding can be useful in many respects - it may lead to an improvement in community understanding of development; and improvement in government understanding of people's reaction to certain guidelines and policies that have been introduced as technical requirements of rural development planning strategy etc.

Equally there is need to build into a rural development planning system, a network of communication between the government, health workers and the local communities, which for local communities may serve as a feedback system which can be quite re-assuring and can add strength to community initiatives. Adequate communication between all the various parties can also eliminate ignorance, broaden knowledge and bring real and lasting solutions to some of the immediate problems of both the government and the communities such as persistent drought, famine, poor soil and irrigation problems, overflowing etc which can be avoided or prevented through long-term and short-term rural development planning strategies.

A network of communication between all the government, communities and individuals can also play important role in conveying understanding of possible practical effects that can be obtained from well-defined rural development actions, which by themselves may act as a catalyst for joint actions for rural development programmes in practice. Within some rural communities, joint action activities may even be extended to include community's responsibility and self-surveying of its development potential

which can identify or reveal those positive assets the community possesses, the constraints which limit the use of these assets.

There are several factors that can be explored in community self-survey of this kind within the context of Nigeria's cultural, tribal, socio-economic and religious backgrounds, by seeking information about some of the assets available to a Nigerian community, for example; information about :

i. Human resources :

- a availability of trained and skilled manpower
- b crafts practised
- c managerial/leadership capacity etc

ii. Availability of land and other natural resources :

- a quality of soil
- b ease of agricultural practices
- c minerals
- d water sources and their conditions etc.

iii. Community History :

- a past and present
- b traditions
- c customs, beliefs etc

2. The Operational constraints to development can be explored by examining for example,:

i. Land ownership and usage patterns

ii. Availability of supporting services eg

- a marketing facilities
- b fertilizer suppliers
- c basic health services etc

iii. Access to and terms of credit eg

- a equity of access
- b knowledge of credit availability

iv. Terms of trade eg

- a bargaining power of community

v. Taxes - Tax system :

- a for the poorer people
- b for the better off
- c insurance services

vi. Rental charges eg :

- a land
- b equipment etc

3. Other associated variables additional to these factors can be examined also and these may include :

i. Environmental eg :

- a weather (floods, drought etc)
- b erosion (of natural water sources)
- c high risk diseases etc.

- ii. Seasonal variations eg
 - a migration
 - b work patterns
 - c agricultural possibilities etc
- iii. Practices/Beliefs eg
 - a acceptance of new technologies
 - b inventiveness of community etc
- iv. Investment possibilities eg
 - a new ideas (fish ponds, new crops)
 - b rural works (roads, drainage channels) etc
- v. Presence and Application of laws : eg
 - a national or federal legislation
 - b local government by-laws to support and promote (PHC), rural development etc

The process of community self diagnosis may include a series of workshops or periodic group meetings where certain critical issues can be discussed, for example, the need for agrarian reform, the need for more equitable pricing and credit practices, the need for high quality and accessible health care etc. Government workers at all levels may be asked to participate in these workshops discussions so that they can be exposed more to rural development problems and be in the best position to increase governments understanding of their responsibilities in the rural communities. Group meetings can also be a learning process for government workers and the communities and may serve as a forum where both governments interest and community interests in rural development are spelt out, a closer

integration that leads to success. Castro of Cuba (1977) and Nyerere of Tanzania (1967) are two heads of State that are known to have promoted community interests in basic health care services and rural development more effectively than several other government ministers in the Third World countries, with their initiatives being concentrated on achieving good results. It is claimed that many rural communities in these two countries have always reinforced their motivation and participated actively with their governments and on reflection; seeing through a feedback information system what have been achieved; which are also a technical justification for greater joint action. In both Cuba (1977) and Tanzania (1967) joint government and community actions in rural development have led to better crop yield, new source of income and protein food, healthier and stronger animals etc, which are all as direct result of establishing new agricultural practices in a pilot farm situation, a fish pond, a local animal health clinic etc. There is sufficient evidence that Nigerian rural development planning system can be as successful as those of Tanzania, Cuba etc, if socio-cultural, financial, political and economic factors do not pose any constraints.

Equally rural development strategy in Nigeria should lead to overall development of community infrastructure with allocation of adequate funds for :

- i. construction and improvement of roads and bridges, markets, dispensaries, schools etc;
- ii. rural employment promotion schemes which expand economy and provide training opportunities for village people, especially the young school leavers;

- iii. schemes designed for integration of a number of scattered and isolated rural communities for the purpose of awarding government grants, subsidies etc for rural development activities;
- iv. slaughter house improvement for proper storage of meat (cattle, sheep, goat etc) prepared for sale to the public;
- v. purchase of scarce commodities such as agricultural equipment, building materials, chemicals and insecticides, fertilizers etc;
- iv. loans to co-operatives, Local farmers, to boost agricultural produce, improve processing and storage facilities, extend irrigation systems, employ more workers etc.

6.3.4 Leadership in Primary Health Care

Leadership in primary health care activities may be exercised as an attribute of position or through sapiential authority, it might be based on a function of personality, it can be seen as a behavioural category. A leader's role in primary health care may be seen in the context of his or her ability to achieve performance from others. Leadership is related to motivation and to the process of communication : being interpersonal influence, exercised in a situation and directed through the communication process, towards the attainment of a specific goal or goals (Tannerbann et al 1961).

QUALIFICATIONS FOR LEADERSHIP IN PHC ACTIVITIES

It is increasingly being recognised that many different Nigerian health workers do not only need to be trained to gain professional qualifications in PHC Administration but also they need to receive, at least, some basic training in the management techniques. In order to acquire the management skills, management training has to be taken on-the-job on continuing basis. In Nigerian medical, nursing and technical education, less valuable training inputs must be replaced by the teaching of management skills to all doctors, nurses etc. Certain subjects, preferably, health economics can be made a compulsory part of professional training curriculum, for example, in a medical school undergraduate training in Nigeria. There can be vigorous use of medical auditing in case of medical doctors and the development of incentives in the remuneration system for them to evaluate both the clinical and economic effects of their behaviour in primary health services. Changes in the budgeting systems for Primary Health Care provision may be introduced so that (PHC) team leaders, senior health managers etc can become budget holders and use them to generate information about costs, enabling them as decision-makers to operate within finite budgets. These budgeting systems could be accompanied, for example, by special financial incentives for extra efforts put into improving basic health care in the most difficult and inaccessible rural and riverine areas of Nigeria. Budgeting experiments of this nature in (PHC) system in Nigeria may need to be evaluated properly in order that not only would all the team leaders and senior and responsible officers in primary health care development in Nigeria led to the waters of evaluation and efficient behaviour, they would also be induced to drink them. Such other issues about medical and other health professions (eg) clinical

freedom and economic efficiency must be built into (PHC) systems as means of improving the services through efficient professional judgements (eg effective diagnosis, treatment of patients etc) but also to some degree, constructive criticisms of any unprofessional conducts, or health standards judged to be improper, inadequate or unhelpful in the eyes of both the public and health professional groups, of which the ultimate goal must be directed to economic efficiency. In all primary health activities the outcome benefits should be maximised, and the services provided should be those most highly valued by Nigerian, society, especially the village people.

6.3.5 Reorientation and in-service Training for Health Workers

Design of the Rural Health Training System : The general training objectives of the system to be instituted in Nigerian rural Communities is to provide the designated staff types with the re-orientation, ability and motivation necessary to function effectively within an evolving and expanding rural health services. The ultimate effect should be an overall increase of service effectiveness sufficient to achieve the previously stated health impact and service output targets as contained in (NBHSS) policy document.

The training of rural health services staff should be conducted in the provincial rural communities health training centres. The primary object of these training centres should be to train the para medical staff who have completed basic training in their respective specialization and are being assigned to rural health facilities in the rural communities, where their various training session may be concentrated on providing managerial and administrative concepts and practical experience. In operating within rural

health centre teams - supervisors training in organization, staff technical and administrative proficiency, normal rural health team operations and team projects, with the team approach concentrating on delivering health services by effective techniques of leadership, co-ordination, communication etc as well as learning health problem analysis, and programme planning techniques-should be learned in an actual health problem situation.

The reorientation strategy for Nigerian primary health care system must embrace a learning-by-doing approach through suitable in-service training programmes for health workers : senior managers, middle managers (supervisors), team leaders etc in which both the trainers and trainees should work closely together at all levels.

In service training programmes in (PHC) to acquire knowledge and practical skill should be part of the general training which all health workers undergo in order to adapt to their new roles in (PHC) activities.

Whilst the policy-makers and health ministers should be re-oriented, for example, to be able to cope with all the necessary changes involved in Primary Health Care development, middle managers - supervisors, team leaders etc must also be retrained to understand the need for their participation, for example, in identifying needs, choosing from existing resources to be deployed and taking decisions about the implementation of appropriate programmes in Nigerian rural communities.

In-service training programmes for all health workers should be adapted to the needs of Nigerian rural communities. It should be need-task-

orientated, and must be relevant and appropriate in terms of needs, technology, socio-economic and cultural environment. It must also be designed to cater in a balance form for all levels of health workers with a content which facilitates development of knowledge, skills and attitudes : is of right duration; has the proper mix of conceptual and practical learning; use the most effective teaching/learning material and methods; has the right type and amount of training facilities; has sound resource personnel to effectively plan, deliver and evaluate programmes. However, it is at the operations level that in-service training courses are particularly important for the day-to day activities in (PHC) in which primary health workers and other health auxiliaries must be heavily involved. It is also true to say that unless appropriate managerial and leadership capabilities are properly developed at the operations level, no great improvement could be expected in the total Nigerian (PHC) system. The reorientation of all Nigerian health workers may be relevant if it enhances effective delivery of health services; leads to efficient performance of health and administrative tasks; improves teamwork approach; leads to optimal use of resources; results in reducing wastages, misuse and delays in the system; permits more objective and rational decision-making and priority setting; leads to balanced coverage of health services; calls for increased public participation and involvement in PHC activities; leads to inter-sectoral collaboration of health with other health-related sectors.

In order to make in-service training programmes effective different approaches can be adopted at operations, intermediate and national levels, for example at community level, health workers should receive short, task-oriented programme, simple to understand, applicable to rural community setting which must emphasize relevant skills and positive attitudes rather

than knowledge. Emphasis would be to adopt effective in-service training schedules in the rural communities of Nigeria to promote and strengthen management skills of health centre/clinic/dispensary managers, community development officers, village health committees - senior officers etc in which training programmes activities may be practised or learned by use of local and traditional institutions : women's associations, religious groups, sports and arts groups, multi-purpose village representatives, local government workers etc. At intermediate level, such as state ministries of health, in-service training programmes may include, for example, intensive courses within the context of the health needs of the local communities in the state, in which locally relevant specialization might be encouraged to deal with, say, eye, ear malnutrition, infectious disease problems which bring the greatest misery to local populations in Nigeria. Attitudinal and behavioural aspects are also to be part of the training programme being themselves pivotal to efficient co-ordination of activities since the State Ministries in this respect may always serve as link-man between the community level and national level (PHC) reorientation activities.

At national level, in-service training programmes for senior managers may be short while the non-health managers should be exposed to some health content. Top level managers should be sensitized to the management needs of their subordinates by occasionally having mixed classes and/or use the output of the intermediate group to prepare courses for the top managers where possible, all programmes should include relevant field-work within (PHC) situations in and outside Nigeria.

The teaching staff and material can help to make in-service training a more positive experience for the trainees, especially by producing

teaching/learning materials and disseminating them to all teaching/learning institutions for health workers in Nigeria; by developing and promoting the dissemination of : relevant NIGERIAN CASE STUDIES; African case studies etc; results of applied research in priority areas and new approaches to the development of health workers and managers of health delivery systems; providing PHC short-term consultants to teaching/learning institutions in Nigeria.

The in-service training programmes could also include workshop on management of health systems which may be used either combinely or separately by groups of health workers receiving training, or include applied research activities in (PHC) management procedures within the socio-cultural context of Nigeria to expose Nigerian participants and trainees to the objectives of attaining health for all by the year 2000. A complete new emphasis away from Western model of high technology curative and hospital medicine should be stressed, to an approach in which (PHC) is instrumental to health education campaign/preventive strategies; inter-sectoral coordination; active community involvement etc with training programmes providing oppotunities for continuous process of learning, practice and review or training programmes based on integration, continuity and adaptability; Proman's approach to training (M Luck 1981); Popular participation Training Approach developed by United Nations (1977). etc.

THE AUXILLIARY HEALTH WORKERS TRAINING

The training and retraining of both the new and existing auxiliary health workers who are going to be involved in primary health care services is

very important in the Nigerian (PHC) system. These auxiliaries range from Traditional Birth Attendants (TBAs), village health workers, nurse, midwives, traditional healers to supervisors who supervise and control the activities of these auxiliary health works mainly in the villages. Training programmes for these auxiliaries must be community-oriented and short but to be followed by continuing education in which teaching methods must include practice, persuasion and guidance as part of regular activities to sustain and improve their knowledge, skills and to develop positive attitudes and self-confidence toward their new roles.

The retraining of traditional birth attendants is particularly important to improve midwifery services in the rural communities with special emphasis being placed on simple but scientific techniques of conducting home delivery with the elements of good ante-natal, and post-natal care, basic cleanliness and hygiene. Re-training sessions must also be used to learn and recognise danger signals in pregnancy and labour while difficult cases must be referred to doctors or trained midwives at an early stage. Traditional birth attendants must also receive training as to how best to motivate village people to use any of the effective methods of family planning.

THE TRAINING OF SUPERVISORS

All the primary health care supervisors and middle managers must receive some reorientation training for their primary health care duties at all levels with an object of improving their leadership role and management capacity. High quality supervision may be achieved through in-service training programmes in which those receiving the training may live for varying times in the village, giving help; providing on-the-job teaching as

required; checking on the health activities of the subordinates and strengthening relationship between primary health workers, the communities and rural community development agencies.

There can be different levels of supervision needing some training of some kind or another in order to achieve work efficiency. The rural communities in Nigeria, for example, may take responsibility for many aspects of supervision, including discipline of the community health workers and the extent of coverage. Supervision may also be undertaken by Village Health Committee leaders, primary health care team leaders, older and more experienced primary health workers etc if some appropriate training in supervision is given to them specifically designed to increase their skills through in-service training sessions; to improve the supply of drugs and equipment with standardisation according to the pattern of diseases in the rural areas; to guarantee a referral system to higher levels in the system etc. Efforts must also be concentrated on introducing at community level, a supervisory training programmes focused on developing concrete managerial and leadership skills in a manner that encourages and supports community organisations and community self-management capacity or initiatives, for example, by incorporating onto such in-service training programmes a means through which the rural communities can develop local insurance schemes for basic health care; develop a revolving fund for local capital investment purposes such as co-operatives to improve local economy. Equally many other specific supervisory training programmes can be undertaken at village level by the communities themselves if properly organised and encouraged to develop some needed managerial and leadership skills that the community already possesses.

In-service training courses can also be arranged for health centre staff who are in supervisory and middle-managerial positions. However in Nigeria, it is increasingly becoming recognised that most of the primary health care activities would rely on efficient supervision by health centre staff as they are the ones in closest relation to primary health care workers. Therefore they need not only to have supervisory training but also must accept supervision as part of their official duties.

However, the Nigerian national health system would still carry the major responsibilities of supervising the technical aspects of health services in the country such as the quality of care, use of drugs, the content of health education, the accuracy of records, the on-going education of health-workers etc after all the necessary supervisory training has been given to many national supervisors for various functions which require different skills.

THE RE-ORIENTATION OF DOCTORS

The majority of Nigerian doctors would need to be re-trained and motivated to work in the rural communities. This is because Nigeria needs more doctors who must be completely devoted to the welfare of the ordinary people, who understand them, who are not separated from them by barriers of cash or class and who can serve their immediate and long-term health needs. To this end, it must be suggested that following a period of trial and error, the policy of selecting some medical students among the interested, willing and community-oriented and eligible candidates (for example, primary health workers, community nurses, midwives, health education personnel, sanitary workers etc) be also considered for admission

into medical school training which takes its root in the villages, where many a time they may have to live and work in the same environment as the peasants; and sharing cottages which may also serve as clinics, showing interest in the community organisations, respecting some customs and practices of the people, sharing meals, platform of brick or baked mud which in some villages serves as bed, helping to carry water and collect firewood for domestic use, join and assist peasants in manual labour, especially during the busy farming periods. Nigerian doctors will also be expected to serve efficiently in the rural communities and meet several of their health expectations and needs; and also maintain a balance between new graduates and experienced doctors, and between different specialities involved in (PHC) service provision, all being expected to undertake any kind of medical work that may arise in the community. To be more equipped for their new role and new service, they should be given some management/leadership and supervisory training, as well as training in community and human relations, and health economics. They have to develop positive attitudes to village people themselves, their customs and beliefs, community organisations etc.

Domiciliary visits should be incorporated to regular activities undertaken by doctors as this may give the village people some opportunities and encouragement to learn more about taking personal responsibilities for improvement of their own health and also a platform in which necessary discussion, suggestions, advice etc may take place between the doctors and individual community members. Also domiciliary visits would reveal to doctors how the majority of their countrymen live and work. Furthermore domiciliary visits should be part of the doctor's regular activities in the rural communities because it is observed that unless Nigerian villagers,

peasants etc are seriously incapacitated, they tend to prefer to put up with aches and pains and go on working rather than take a day off to go and see a doctor.

The main objectives of re-training Nigerian doctors in (PHC) activities could for example, be to massively produce 'Medical Brigade' type of Barefoot doctors trained in the People's Republic of China, with such training programme in Nigeria specifically designed to meet the health needs of Nigerian populations. The training, should clearly be adapted to Nigeria's cultural, socio-economic and political abilities, in which greater emphasis must be placed on eradication of famine and hunger, malnutrition, infections and contagious diseases etc throughout the country. Doctors role in the fight against these could be more effective if in course of their training they relate to the people and help medicine to become established, taking its root in the rural communities of Nigeria, where a lot of preventive work, in connection with, for example, water-borne diseases could be done. Most of the drinking water in several Nigerian villages comes from wells, rivers, or springs which are easily contaminated with disease-producing germs. The practical training of doctors in the village can be successfully undertaken if they win the active support of village people, use posters, lantern slides, microscope near a contaminated water source to demonstrate preventive health education programmes, whereby the villagers themselves can see the germs swimming about in the unclean or unsafe water. Similar initiatives may be taken for disposal of human and animal excreta etc. However, if Nigeria has to approve the 'brigade production' of doctors in order to meet the basic health needs of the people, certain factors must also be considered such as long-or-short term unemployment of too many doctors at a time; careful consideration of the

quality and standard of medical care/science; the resources available for their training; opportunities for advancement and promotion; better conditions and incentives. But more than all these, Nigerian universities should consider reducing the training period for doctors from the present six year period to say 4 years (Lambo's Plan 1977) and also to change educational strategy to meet the trend in development and civilization. More doctors would be needed as about 75 per cent of the Nigerian population still have no access to decent medical care.

6.3.6 Health for all by the year 2000 and its managerial implications for Nigerian PHC effectiveness

An effective primary health care system in Nigeria would embrace at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition., an adequate supply of safe water and basic sanitation, material and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

The implementation of these programmes may have some managerial implications for health for all by the year 2000 strategy in Nigeria. The immediate challenge might be to launch a sustained process of change in Nigeria which will yield significant improvements in health status of its citizen by the year 2000. Health for all by the year 2000 policy in Nigeria would require the development of a health system in Nigeria which permits inter-sectoral collaboration which must be supported by a clearly defined

political will and to follow his through with the development of nation-wide primary health care programmes. The Health for all policy would also require the development of a health system which encourages and mobilizes full and unconditional community participation. This participative thrust may further pose a challenge to all those who are responsible for training in health management, in a sense that the Nigerian health management authorities responsible for management training programmes cannot legitimately continue to prepare health management courses only for top and middle level health workers in Nigeria and ignore those at the peripheral and community level who provide health care to the majority of Nigerians.

Health for all concept in Nigeria may demand the development and utilization of health teams, which must include members of the community other than the health professionals only, in which case, the management training task may also be to find ways of ensuring that an operational relationship is established between the Nigerian communities and the health services systems : if these Nigerian communities are to be able to manage their health care activities and health care programmes, they must be taught how to collect and analyse data and how to hold working meetings to discuss community health priorities, community development matters etc. These communities should also know how to make use of data for decision-making and to mobilize needed resources and evaluate progress. These operational management activities on behalf of the communities must then reveal the extent of community involvement, bottom-up planning and decision-making processes to make (PHC) in Nigeria more effective instead of being a process that is based on top-down model whereby all these activities are done on behalf of the people which is

no longer valid and acceptable. Health for all policy in Nigeria may require a learning-by-doing approach in which all the management trainers and trainees at all levels in the system must work closely together in order to achieve efficiency and effectiveness of service. Health personnel at all levels should equally be sensitized to the real health needs of Nigerian, especially the health needs of the village people. Community participation in (PHC) management and decision-making should not be overlooked by focusing nationally largely on problems of budgeting, logistics, information, resource management, for general and teaching hospitals. Decentralization of these management activities would be very helpful, for example, local financing may become the approach needed to overcome budget constraints; community-operated supply and maintenance depots may solve some of the logistic problems inherent in the Nigerian health systems; community generation and analysis of information may act to stimulate the development of more relevant information systems that would support primary health care system in Nigeria; community self-diagnosis of community problems and community supervision of activities, resources available for (PHC) may stimulate greater community spirit and use of labour and skills of the village people. Inter-sectoral collaboration of health and health-related agencies must be instrumental to achieving effective (PHC) in Nigeria. Therefore the communities seeking better schools for their children, more convenient access to water, increased supply of food etc must not receive an indifferent and unsympathetic response from the health sector and from institutions teaching health management procedures and skills, as primary health care development and primary health care effectiveness require combined intersectoral forces directed to attaining health for all by the year 2000. However, the Nigerian health sector itself must continue to play a key role by focusing

on priority health (and community) problems in the Nigerian communities and building the gap between health and other sectors by concrete acts which link health actions to words. In order to achieve (HFA/2000) in Nigeria, major steps must be taken both at macro and micro levels of government, to generate managerial capacity that is essential to (PHC) effectiveness.

At macro-level, the managerial functions of Nigerian ministries of health will have to be reviewed, in which case, the challenge would be for ministries of health to provide effective leadership by introducing new ideas and policies; identifying major health problems and on determining national health policies based on an inter-linked process so that local needs give rise to central responses and social needs give rise to technical responses.

At micro-level, (HFA/2000) for example would require self-reliance of individuals and communities and their participation and involvement in the organisation, operation and control of (PHC) activities through decision-making and planning procedures.

Health for all is not a single finite target, rather, it is a process leading to a progressive improvement in health of the people in which efficient (PHC) management system may help to make it a positive experience and a reality in Nigeria.

BASIC HEALTH CARE PROVISION

In Nigeria the basic health care provision strategy must lead to changes in health status of individual but these changes in themselves must not be restricted to health care alone - changes to improve nutrition, sanitation, living standards etc should all be taken seriously important. Many other changes may require a fundamental redistribution of health resources from the service of those who had least; a commitment to people's own self-reliance and mutual help in maintaining their own health through mass health education programmes with different local neighbourhood organisations : special nationwide campaigns, techniques that emphasize the importance of health for families and individuals etc.

In Nigeria (PHC) system, basic health care provision should at least embrace most if not all those essential elements constituting the Declaration of Alma-Ata : The International Conference on Primary Health Care expressing the need for urgent action by governments, health and development workers and communities to protect and promote health for all the people.

THE ALMA-ATA (1978) (PHC) DECLARATIONS ARE summarised as follows :

"The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration :

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary Health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bring health care as close as possible to

where people live and work, and constitutes the first element of a continuing health care process.

Primary health care :

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least : education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated effort of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns the benefits every other other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources.

6.4 RECOMMENDATIONS TO LOCAL HEALTH AUTHORITIES/LOCAL GOVERNMENTS

They should train PHC Managers : especially at health centres and dispensaries in different important activities :

a) Awareness:

1. All health personnel should learn health education techniques, on individual and group basis.

2. Provide an organised systematic and widespread health education service

b) Motivation:

1. Provide better information concerning health services. Group discussion with village population.
2. Train and supervise TBAs. Contact traditional healers and seek their co-operation.
3. Improve services by changing procedures.
4. Encourage community participation in defining health needs

c) Contact:

1. Increase the number of health facilities and build more where transportation is difficult.
2. Organise mobile health units to reach out to isolated and riverine areas : mass immunization etc.
3. Use voluntary assistants for certain health tasks.

d) Diagnosis:

1. Review curricula and reorient programmes of all training institutions towards community health and diagnosis, treatment of current diseases.

c) Prevention:

1. Mass distribution of certain essential drugs at village level.

2. Clinics on rotation by dispensary and health centre staff in villages where and when possible.
3. Provide integrated curative and preventive services.
4. Improve co-ordination of activities at health centres and dispensaries.
5. Introduce trained female staff to deal with mothers and children and referral of patients to health centres as required.

HEALTH RESOURCES

I HEALTH FACILITIES

New approaches to delivering health services in rural communities in Nigeria should be designed to make maximum use of existing manpower and money available.

Given the dimension of health problems in Nigerian rural areas and the limited levels of direct government financial support available, every effort must be made to design village services that are self-sustaining and capable of reproduction on a nation-wide basis. Villagers presently invest a considerable amount in private health expenditure (traditional care, shrine and religious healing, TBAs etc) and have a pressing desire for improvements in their access to primary health care services.

HEALTH EDUCATION : It should not be enough to limit health education to schools only. It must extend to all members of the

rural community. A successful health programme must depend partly on the planners and partly on the co-operation of the village people. To have confidence in the programme, the people must be educated through such other methods such as mass media, radio and local news papers and health articles written in the most acceptable local languages - Ibo, Hausa, Yoruba etc.

Information for policy making :

- a. Cost and population coverage analysis. A further analysis, with the benefit of all needed information and materials, should be undertaken of cost and population coverage of the rural health centres. If possible, the analysis should detail the cost of individual rural health centre programme sectors, for example, family health, laboratory services, drugs etc. A policy of increased coverage should embrace :

- a. modernization of rural community hospital facilities
- b. construction of more health centres and dispensaries to increase current capacity
- c. Preparation of additional manpower levels
- d. Provision of maternal and child health and general health care to mothers with young babies. etc.

- e. The expansion of health services beyond the network of rural health centres and into the villages of Nigeria could require state Ministries of health to be willing to try a number of different approaches: A close examination of PHC approaches undertaken by many countries, especially where (PHC) has been effectively implemented, may be helpful to Nigerian PHC management procedures. However, Nigeria will have to adopt its approach to its own problems and resources, and in doing so will ultimately have to develop unique solutions in response to Nigerians health needs in the rural communities.

Reorganisation of Ministries of Health - The conventional medical services in Nigeria and its management have proved insufficient and unable to meet the basic health needs of the vast majority of Nigeria people, hence the urgent need to develop appropriate and efficient administrative machineries at national, state and local government levels, where major health policies and decisions which affect the majority of Nigerians are taken. The renewed effort, especially at federal and state levels, should be to review most urgently the functions of ministries of health in relation to the whole national health services with most attention certainly paid to primary health care policies : finance, manpower, leadership etc.

State Ministries of Health - For PHC in Nigeria to be effective, it is essential that the agency responsible for health services delivery - state ministries of health should design an approach which is fully supported not only by health policy makers but also by those responsible for implementing it in the field.

SOCIAL POLICY IN SUPPORT OF (PHC)

A broader package of policy improvements should be directed to improving PHC effectiveness nationally through expansion of social services to the poor, reform, increased development expenditures in the rural areas, stimulation of small scale enterprises etc.

Wider participation of the community and village people in PHC development processes, planning, decision making should be encouraged and measures to achieve this should include decentralised government administrative systems and support for relevant voluntary organisations in PHC activities.

Population growth policies should include national population programmes aiming at a satisfactory balanced between population and resources and making family planning freely available to Nigerian people. Population control should be based on effective, long term demographic planning policies and improved family planning methods.

Malnutritional problems in Nigeria should be eliminated or reduced through implementation of practical remedies:

- grow more food and improve economic conditions of people
- study the value of foods so as to make a wise selection of food stuffs

eat foods that are nearest to nature - fresh meat, vegetables, fruits etc.

school meals helpful to school children

For PHC to be effective in rural Nigeria, there must be an end to mass hunger and malnutrition. Special attention should be given to agricultural development - irrigation, agricultural research, storage and increased use of fertilizer and other inputs, and fisheries development.

Agrarian reform is of great importance in Nigeria to increase agriculture productivity and to put higher incomes into the hands of the poor.

Although legislation on many aspects of environmental health are lacking in Nigeria, the few that are applicable to any particular area should be enforced by local health authorities as required. The making of standard and realistic new legislation on the essential aspects of rural sanitation should be encouraged by these authorities also.

Improving efficient systems of transport and communications, rural development and general infrastructure in rural areas must form part of the process of change for health improvement through environmental strategy.

1. Location of Health facilities which offer:

- a. accessibility in terms of cost and distance (i.e. cost which the community can afford; and reasonable travel time).

- b. increased population coverage of health facilities and resources e.g. number of doctors per unit of population or number of people for whom a health clinic or dispensary has been established.
- c. adequate level of finance e.g. local health insurance schemes minimum prescription charges etc.

2. Health and nutrition:

Education programmes designed to identify and show how to use local food crops that are nutritionally rich in proteins, vitamins, iron etc better, which are also culturally acceptable.

3. Housing improvements through:

- a. adequate ventilation
- b. reasonable accommodation
- c. good surrounding and tidy environment
- d. damp-free homes etc

Community health must be strengthened and supported with:

Preferential allocation of health resources to the social periphery.

Improvement of human environment with the progressive provision of safe drinking water, waste disposal system, and clean air in all the communities.

Community mobilization in planning and development, including promotion of collective responsibility for the health and health care of the communities and their families and individuals.

6.5 RECOMMENDATIONS TO VILLAGE PEOPLE

SANITATION:

1. The village people should be encouraged to provide latrines in their homes and must be educated to use them properly.
2. As there is no paid sanitary labour, the village must be instructed to dispose of their refuse in an appropriate and safe manner. This may be done for example, by incineration or composting in refuse trenches.
3. **REFUSE DISPOSAL:** Every community member should be motivated to provide the safe disposal of sewage and rubbish. This should ensure clean surroundings and avoid diseases by removing conditions favourable to fly breeding. Pit latrines, incinerators, dustbins etc should be among the simple ways of refuse disposal in rural communities.

4. PURITY OF FOOD : The hygiene of food. The food for people should be pure and clean before and after cooking. Health is likely to be impaired by poisonous substances gaining entrance into people's foods. The hygiene of food means cleanliness in its preparation, cooking and storage. The kitchen and kitchen furniture should be clean and in good repair. Cooking and feeding utensils should be thoroughly cleaned immediately after use and stored in a special place - cupboards or food safes. Cooks and others concerned in preparing food should wash their hands before touching the food and their personal habits in connection with the natural functions should be scrupulously clean. Thorough cooking is essential; steaming, stewing or boiling are safer methods of cooking.

Food sanitation. Village people should keep their food pure and wholesome by insisting that:

. All persons handling other people's food must wash their hands, not use other people's plates or spoons without washing them; not cough or spit over the food of others etc.

. In case food has been visited by germs, the germs should be killed by cooking etc.

5. Health Education programmes must be broad based. Simple explanations of factors helping the local spread of disease and

ways in which the villagers can help to interrupt transmission should become part of health education package which also secures community involvement in health education activities and which lays emphasis on personal hygiene through education. Community must also consider the use of role playing, songs, dance, folklore, drama and so on as attractive methods of disseminating health education programmes. In this way these programmes can gain wider acceptability and can be adapted to local conditions and the custom and beliefs of Nigerian people.

6. As part of health education package, new cheap effective and locally available health education materials and methods should be adopted by villagers in the areas of housing, water supplies, and household disposal - proper disposal of refuse and excreta.
7. Disease control campaign in the rural areas should include not only environmental improvements but personal health habits should also be effective disease therapy at individual level.

6.6 RECOMMENDATIONS TO HEALTH CENTRE/DISPENSARY MANAGERS AND ADMINISTRATORS

These recommendations are aimed at improving service efficiency in the following ways.

HEALTH WORKERS

Re-orientation and inservice training strategy for health workers in (PHC) is needed. A completely new emphasis away from Western model of high technology curative and hospital medicine to an approach in which (PHC) is instrumental to health education campaign, preventive strategy, inter-sectoral co-ordination, active community involvement, decentralisation of (PHC) activities (etc).

New approaches to delivering health services in the rural communities of Nigeria should also embrace some management procedures adaptable to Nigeria (PHC) situation, for example : planning for both health and rural development; decentralization of PHC activities and decision making; reorientation of health workers through in-services training programme in (PHC) etc.

HEALTH CENTRES AND DISPENSARIES

- a. **FAMILY PLANNING:** Family planning services should be included as part of the regular package of family health services and health education programmes undertaken at health centre/dispensary.

- b. RURAL HEALTH CENTRE CLINIC OUTREACH: Given the limited population coverage of basic health services it is important to consider new strategies for rural health delivery, such as identifying and developing key areas of training for village health workers: immunization, health education, paramedical use for routine care: patient flow and referral system and staff task description detailed analysis of the disease patterns commonly found and treated in rural health centres and dispensaries may indicate that it is both feasible and desirable to make far greater use of paramedical personnel in treating routine cases. Rural health centre managers should focus on the prevention and treatment of the most common diseases. All supplies, equipment, training, supervision and written staff materials should reflect and support this focus.

In order to provide services in a manner that will be both economical and maximally effective, high priority must be given to those currently at greatest risk in Nigerian rural communities - mothers and young children.

Emphasis should be placed on programmes aimed at the prevention and treatment of the most manageable infant killers - diarrhoea, whooping cough and measles.

The essentials of nutrition should be communicated to mothers in a way that will have practical application for the feeding of their children and themselves.

Greater awareness should be developed at the village level of effective steps which can be taken at the onset of an illness in children, and appropriate steps to be followed if village resources are not appropriate for treatment: referrals, home visitings etc.

Traditional health practices consistent with good health should be encouraged and supported. Those practitioners presently in greatest use such as bone setters, traditional birth attendants etc should be used to determine how they can be used more effectively in both a treatment role and in the referral of patients to appropriate sources of treatment outside the village.

Many of the illnesses encountered in the village setting could be treated by someone residing in that village who has had training in the essentials of illness and health care. Indeed many primary health workers should be trained in (PHC) and their new role should be extended to caring for peasants and their families who are affected by general endemic diseases and malnutrition in the rural communities.

Experimental programmes making use of both traditional health resources (TBAs, bone-setters, etc) should be encouraged and promoted at dispensary and health centre levels to support PHC services where such practices are evaluated and properly monitored to make sure that they are safe with the people.

6.7 IMPLEMENTATION OF RECOMMENDATIONS

These recommendations could be implemented by the different agencies mentioned above on a short-term or long term basis. The strategies adopted by each to implement them may vary.

Differences may also arise in both the concept and meaning of the terms 'short-term and long-term' programmes. Different groups may also have different preferences and priorities of programmes to be implemented first and when to implement them. However for the purpose of distinction and clarity, the short-term PHC programmes/activities could be scheduled to be implemented under a three-year period. The long-term PHC programmes may run for many years - 5, 8, 10 years etc.

A successful implementation of both short-term and long-term PHC programmes in rural Nigeria may well depend on:

1. The type and nature of the programme.
2. Resources that are available - finance, manpower, materials and equipment.
3. Political situation:
 - a) the stability of government
 - b) Government will and commitment to PHC systems
4. National Economy:
 - a) Gross National Product (GNP)
 - b) Gross Domestic Product (GDP)

5. Degree of community involvement, participation and co-operation in PHC activities.
6. External support eg:
 - a) WHO
 - b) UNICEF
 - c) FAO
 - d) IMF etc
7. Cultural constraints - superstition, customs, traditional beliefs etc.

The examples of PHC programmes that could be implemented in rural Nigeria on both short-term and long-term basis, where feasible, may include the following:

1. Short-term PHC Programmes:

The Implementation
Agency:

Examples of Short-term PHC activities to
be implemented:

A. Village People

1. Environmental Health Sanitation - better construction and use of latrines, refuse disposal etc.
2. Personal Health hygiene
3. Food and nutrition education campaign
4. Maternal and Child Health Education
5. Control of Diarrhoea - Oral Dehydration etc.

B. Local Health
Authorities/Local Government

1. Basic health provision
2. Environment Health and Sanitation improvement
3. Preventive Health Care
4. Training of Primary Health Workers
5. Motivation of Health Workers
6. Family planning
7. Provision of social service
8. Rural Development

C. State Ministry of
Health

1. Co-ordination of PHC activities in the whole provinces.
2. Administration and Supervision of quality and standard of PHC services
3. Preventive Health Education programmes
4. Defining and selection of important health problems in the rural communities
5. Distribution of Resources allocated to PHC programmes to rural health centres, hospitals etc.

D. PHC Managers and
Administration at
Health Centres and
Dispensaries

1. Day-to-day administration of PHC activities at health centres
2. Developing job descriptions and specifications of staff
3. Co-ordination of PHC activities at health centre - level
4. Developing training programmes
5. Distribution of supplies
6. Internal communications etc.

Long-term PHC Programmes:

The Implementation
Agency:

Examples of Long-term PHC activities to
be implemented:

A. States Ministry of
Health

1. Professional training of health workers including re-training schemes
2. Formulating Agriculture and food policy in conjunction with Ministry of Health
3. Planning of PHC services, including social services
4. Preventive Health strategies and campaigns
5. Health for all by the Year 200 policy (HFA/2000)

6. Allocation of health budgets and resources to rural communities

7. Developing indicators for monitoring PHC effectiveness etc.

B. Researcher in PHC Management and Health Systems

1. Health research into PHC effectiveness in the rural communities

2. Operational research and systems analysis of health centres, dispensaries etc

3. Family Planning and research in varied contraceptive methods suitable for village women

4. Constraints to:

- a. achieving health for all Nigerians
- b. community acceptance of new ideas and changes in PHC system
- c. improved relationships between the community and health workers

5. Social organisations; customs and culture of village people in Nigeria

6. Developing alternative approaches to paying for health care by the village people which are more acceptable to them.

7. Developing traditional health practices consistent with good health and determining how the traditional practitioners can be used more effectively in the provision of PHC services.

CHAPTER SEVEN

RESEARCH CONTRIBUTION TO KNOWLEDGE

7.1 AIM

This chapter attempts to bring together the important contributions of the research programme, the potential benefits that could be exploited from the research to improve (PHC) effectiveness in rural Nigeria. The Research Contributions highlighted have subsequently been classified under two main headings viz contributions to the village people and rural community; and contributions to knowledge.

7.2 CONTRIBUTIONS TO VILLAGE PEOPLE AND COMMUNITY

The Research Programme developed strategies for testing effectiveness of PHC in the three rural communities: the provision of appropriate health care services that are sensitive to the needs of the village people; the adoption of a policy for the provision of such appropriate health care services, taking account of the differences between Ibo, Yoruba and Hansa in culture, language, religion and in the uptake of the available health services; health facilities available to the community and so on.

The research also outlined proposals for the development and implementation of these strategies, as well as the work plans for implementing, monitoring and evaluating them (as indicated in chapter five).

The Research study created an awareness of the importance of effective (PHC) in the rural communities and this in turn could strengthen many of the fragile, artificially - nurtured (PHC) programmes formerly in existence and turn them into strongly-rooted community resource.

It is also realized that the research did bring both the providers of the service and the consumers of the service together at local levels to exchange their views about the existing (PHC) situation and about new developments. This does not only motivate the village people and raise their group efforts in community and group activities in (PHC) but also bridges the gap between people in these rural communities and local health agencies and other institutions: agriculture, education, social welfare etc.

In such events when the rural communities met together, matters of social or economic value were discussed by individual members of the community groups which helped them to receive support and co-ordination in their efforts and to identify and alleviate problems as they saw them in their rural communities and in many other Nigerian villages too.

The research made the village people to realize that information can be used to good effects in support of efforts to improve basic health services. By showing village people that they as individuals and groups could improve their own health e.g. through health education system, personal health practices and improvement, the research strengthened their self-esteem; that prime requirement for health for all the Nigerians by the year 2000.

The Research has highlighted one of the critical problems facing the provision of basic health care services in the rural Nigeria. This is problem of the missing-link between some present systems of health care delivery and the rural communities they purport to serve. I have made a number of important recommendations to combat this serious problem - active engagement of the village people in the system, closer co-operation and understanding of the community leaders, the grassroots etc and the health workers, administrators etc.

The Research investigation in the rural-setting has given the researcher some deeper understanding of the ways of the Ibo, Hausa and Yoruba communities, their habits and customs, social organisations and their sensitivity to people's needs, self-definition of their own problems, self-determination to changing attitudes to accepting modern health care and self reliance in mobilising local resources available to make (PHC) more effective etc. Without these results, the research contribution to knowledge would have been minimal and limited in its benefits.

There are a number of other contributions that followed the research project, for example, it provided information and insights about Primary Health Care ineffectiveness in the rural areas of study: Ibo, Yoruba and Hausa communities, and offered suggestions for an improved PHC system in the rural Nigeria. Community participation as a powerful tool in basic health services programme was seen to be evident from the real dialogue between health service professionals and community/patients, for example, different groups of village people took interest on the idea of participative management in (PHC) for a variety of reasons:

1. To know what their local community wanted from its community medical practitioners and hence wished to have representatives from all local organisations: the church, (TBAs), traditional doctors, community leaders, women's organisations etc.
2. Other groups wanted a more open kind of community medicine, via a committee elected by patients to meet occasionally to discuss different health topics for necessary improvements.
3. A different entire group wished that patients are given a say in the running of health centres and dispensaries and public opportunity for investigating patients' complaints, for example, how well health services meet community needs and expectations.
4. The last group wanted to voice their opinions on conditions at particular health centres or dispensaries within their own local community.

7.3 RESEARCH CONTRIBUTION TO KNOWLEDGE

To some people the word research may imply a complex system that has to do with laboratories, mathematical theories and scientists in white coats. Research work is thought to be complex, difficult to understand, and of little interest or concern to ordinary people. Primary Health Care Management Research is not quite like that - it is best characterised by relatively simple studies of practical health problems, carried out mainly in the rural communities with the involvement, not only of those who organise and provide care, but also of those who use it.

The Researcher was able to develop some comprehensive Research methodology which embraced a variety of techniques, including Health Attitude Questionnaires, Interviews, Observation, Group Village Discussion, Case Studies and Follow-up, strategy designed for studies of PHC situation in Nigerian rural communities.

In addition the research process for the whole programme was developed to include research process, and programme of work which many other researchers in Health Systems may adopt or modify.

The success of primary health care management research of this nature must be measured not by the mere production of theoretical recommendations, but by whether those recommendations are used to good effect to promote health and improve basic health services in the rural communities.

As well as producing technical reports on the survey which could be useful and demanded, for example, by the World Health Organization (WHO) who assisted with the funds for research travels; and the authorities who assisted with the researcher's rural postings, selection of study areas and fieldwork approval; the field-work equipped the researcher to be able to prepare and produce a much comprehensive thesis which sets out the relevant findings and conclusions of the research.

The research investigation produced new information which could be used in a number of ways by, for example, the Nigerian Local Health

Authorities; State Ministries of Health and so on, to improve PHC effectiveness. The new information, that is gained from the research work could, for example:

1. Permit a better understanding of health problems in Nigerian rural communities: malnutrition, measles, whooping cough, endemic diseases such as worm infestation etc.
2. Assist in more rational health planning to enable future demands in basic health care to be adequately met.
3. Result in more effective and efficient basic health care, which at the same time is better attuned to Nigerian culture and tradition, and health needs of village people.
4. Determine patterns of services available to rural communities.
5. Actively involve people in the study of their own problems, in the care of their own health and enable them to participate fully in the decision-making process about health and community matters.
7. The new information gained from the investigation could also provide opportunities to involve policy makers, the providers of care and the people themselves in a general strategy aimed at primary health care development and improvement to make (PHC) more effective in the rural Nigeria.

The research findings and conclusions could make some contribution to knowledge in other respect too, for example, such findings and conclusions could be used to design broader strategies for effective primary health care in Nigeria: government (political) commitment, active involvement of village people, decentralization of PHC activities, reorientation of health workers, good leadership and improved supervision etc being just few examples of a package necessary for effective (PHC) system in Nigeria.

These strategies could in turn be used to explore and test the possibilities of the various options to seek some conclusive good results, eg testing the most effective approaches of (PHC) systems in which the people are sufficiently involved in identifying their own problems, in decision-making process, and in the planning process of (PHC) activities, instead of receiving imposed ideas from the management to the people (i.e. top-down model of management in which decisions are imposed from the above)

A researcher of this kind could make some contributions to knowledge in other important areas also. The potential of the research need to be exploited so as to make an efficient use of the scare available health manpower, to mobilize and involve these additional health manpower resources that exist in the rural communities, and by strengthening the cadres of primary health workers, to minimize the dependence on Nigerian conventional curative health systems. Therefore by virtue and implication of this research, its findings and conclusions could be useful in promoting a balanced primary health care service development throughout the country, training many more Primary Health Workers and health auxiliaries and equitable distribution of services/resources between the rural

communities. The research surveys in the three rural communities studied in the north (Hausa), East (Ibo) and West (Yoruba) identified the general and specific problems of these communities and indeed the rest of Nigerian rural communities and these have been shown in the general findings and conclusions of the investigation which summarised some important deficiencies.

For example, deficiencies in the availability of basic health services, community social services, health education, nutrition programmes, school health and so on in the villages of study were identified and the results were used by community representatives in presenting their case to local health authorities and also to ask state ministries of health for improved services. The survey investigation itself received community support with the community leaders, school teachers, traditional birth attendants, religious and community leaders, health workers etc fully participating and co-operating with investigator(s) in most of the research activities. The research has provided a useful example in a developing country (Nigeria), the possibility and the benefits of undertaking a research programme in primary health care management within a rural setting and at an advanced level (i.e. Doctorate level). Furthermore, the research hypothesis testing produced a platform for evaluating and monitoring the strategies for effective PHC programmes to show actual effect of innovations in (PHC) services provision and to compare it with the expected effect: What worked; what did not; areas of further research etc. Therefore the replication and extension of this and similar Health System's research programme may really depend on the outcome of some of the recommendations that have been made for implementation to different authorities.

In a way the implementation of these recommendations could be part of the process of social change needed to improved service effectiveness in all the rural communities of Nigeria.

While the job of implementing some of the recommendations on long-term basis may be extremely difficult because of shortage of funds, it is not impossible to implement some of these recommendations on short term basis in the light of resources that are available. A follow-up strategy might be necessary to see how some of these recommendations have been or are being implemented and also to gauge fully public reactions to the work that has been done in these rural communities to see if further investigation is necessary in the future and in what areas of service.

7.4 AREAS FOR FUTURE (PHC) RESEARCH INVESTIGATION IN NIGERIA

7.4.1 Research For (PHC) Policies

It would be naive to assume that the Nigerian National policies on primary health care development are based firmly on objective survey data; the realities suggest rather different determinants which often tend to be too political. Broad decisions about (PHC) policies are based neither on reliable statistics nor on any systematic information but more on the subjective hunches of politicians. Health policy making in Nigeria is inspired by political creeds; the philosophies of the ruling party (for example, the then ruling party of the recent civil government administration) are likely to be dominant influences. Objective health

survey data when collected at all, may play a limited role in development of health policies. It is imaginable that there are times when the right kind of research may have been undertaken before policies were developed, but the findings have been largely, if not entirely, ignored because they challenged patterns of thought and behaviour, derived perhaps, from political expediency. There is need for application of survey techniques to guide policy-makers in the Nigerian (PHC) system.

As has been observed in the study, community health surveys have successfully uncovered unmet needs, particularly those referring to those health conditions and sub groups of the population that escape the attention of established medical channels. Such is the situation that Nigerian rural communities are essentially the main casualty sub group that escape the attention of both central and state health establishments. Primary health care surveys may be able to highlight inefficiencies in the existing system of health care. Too often in Nigeria, these services are either over-utilised, for example in the cities, or under-utilised, fragmented, lacking in continuity and comprehensiveness and of low quality e.g. in the rural areas. Research investigations into (PHC) policies in Nigeria may serve to improve basic health services, and can be quite beneficial, at least, in support of any public commissioned inquiry about community and public health provisions, standard and quality of service and so on, and may contribute to a non-contentious policy-making. Furthermore such research investigations may be programmed to, or in support of official health policy. In all these, health survey data may be seen as methods of opinion and fact gathering and the survey findings may indicate, for example, concern about remoteness and a wish for greater community participation and involvement in (PHC) decision-making and planning and other local and

rural development matters, which would necessitate giving the local communities greater responsibilities in these spheres.

By collecting and analysing health data from Nigerian rural communities, the Nigerian health planners and decision-makers may be in the best position of evaluating alternative strategies that would make (PHC) more effective in Nigeria, with, of course, specific impact on management procedures; political commitment; planning for both health/PHC and rural development; decentralisation - political decentralisation, administrative decentralisation and decentralisation of planning; leadership approaches and leadership styles - democratic, autocratic, laissez-faire; Health for All by the year 2000 and its managerial implications for the Nigerian (PHC) system; Basic health care provisions and the reorientation of health-workers through in-service training in several established health institutions of Nigeria - health centre, dispensaries/clinics, hospitals, Ministries of Health and so on. However, an antagonising situation may always arise where, for example, (PHC) policies have been devised without, or with little, anterior (PHC) research investigations done, and have themselves become the foci of attacks by the Nigerian public in general, and the village people in particular, together with others who may be acting as pressure groups - Nigerian trade unions, religious leaders, government departments, voluntary organisations and so on.

It can be said with some certainty that politicians are suspicious of survey data and certainly (PHC) survey data are no exception. Politicians tend readily to reject opinions and research findings which contradict their own entrenched beliefs. But certainly a well researched (PHC) programme in Nigeria may confirm the impressions of what the Nigerian public is thinking

about health provisions and their adequacy, acceptability and effectiveness, especially in the rural communities. So far it would be equitable to assume that research into health needs of Nigerian people in the villages has received scant attention and this is why public and community desire for (PHC) research programmes in Nigeria is growing and must be accelerated to meet the demands being made by our growing population for a decent health care system. It is equally conceivable that these research investigations must not be restricted to health services alone but may be extended to other important areas that determine individual's health status such as housing and welfare systems, household food consumption and expenditure survey, general household survey, population surveys and other social and health-related research-oriented programmes which could directly improve the general standard of life for many Nigerians. However, the general level of research standards and practices needs to be substantially high and effectively monitored to avoid resources voted for (PHC) empirical research investigations in Nigeria being wasted.

7.4.2 The Need For (PHC) Research Programmes

Primary Health Care - social research investigation into people's health needs and other social services will be very important in Nigeria and relevant to (PHC) development in the rural areas. The reluctance to adopt a research-oriented approach to primary health care policy decisions in Nigeria is so marked at the national, state and community levels, where essentially, many surveys ought to be sponsored more vigorously both by Government departments and by group of individuals to increase (PHC) effectiveness nationwide. At community and state levels, which in Nigeria, are much nearer to individuals and households, objectives and up-to-date

information about people's health and social needs appears often to be lacking. The role of research in (PHC) system tends to be misunderstood by officials and is often perceived as not relevant. Added to this problem is the fact that community health and social needs are fragmented in Nigeria and have not been properly co-ordinated to provide a coherent and more effective (PHC) service.

Given that resources available are limited, (PHC) research findings in Nigeria may present tentative solutions to our basic health problems which if implemented may help, to improve effectiveness of service.

7.4.3 PHC Surveys Concerned With Population Studies, Health Education, Drug Therapies

Some important (PHC) surveys in Nigeria may be concerned with population: trends and patterns of infertility, over-population, birth control practices; with health education and the effectiveness of poster campaign necessary to mount a public information campaign in order to determine, for example, whether the need exists for specific health education, or where this exists, to give guidance in planning health education programmes and also in monitoring their effectiveness.

Primary health care programmes in Nigeria can also be broadened and modelled to include empirical investigations into, for example, ways and methods of evaluating drug therapies for basic health care; or the health economics; of composition and deployment of community nurses and health visitors in the village; or costs and benefits of health screening - whooping cough, cholera, measles; or primary health preventive measures - anti-smoking campaign and anti-drinking measures.

7.4.4 Surveys For Housing Standards And Amenities In The Rural Areas

Many research projects in (PHC) in Nigeria may be quite useful if they are designed to suggest relevant and appropriate housing standards in the rural communities by, for example, evaluating prospective housing amenities that are required and subsequently recommending guidelines for setting new minimum standards for human habitation, setting community preferences in housing and considering environmental variables such as: pedestrian safety, journey time to work, village market facilities, community social clubs, unnecessary noise from traffic, where motor vehicles are used fairly regularly - this is not however considered to be a major environmental problem of several Nigerian rural communities, but, both air or sea pollutions are, which could be controlled or prevented to avoid health hazards occurring in most of the areas where as a result of oil-drilling activities and gas escape, several villages in River States or parts of Warri have suffered terribly: sea pollutions have killed off fish and made marine life non-existent, farmlands have been ruined and so on.

7.4.5 Public Health Attitude Surveys About Mental Illness And Mental Patients in Rural Nigeria

Public attitudes towards mental illness have not undergone considerable change in Nigerian society, similar to changes that followed the Aro village Psychiatric experiment pioneered by Professor Lambo.

Advances have not been made fast enough to understand through research studies, the problems of the patients and their families and the economic

pressure and hardship which affects families with mental patients. Research studies may also be appropriate to investigate the nature of care and treatment which the Nigerian mental patients require for either total or partial cure. (PHC) research can concentrate on finding the social and economic factors that give rise or promote mental illness in Nigerian society by, for example, identifying or discovering the degree of knowledge about mental illness, attitudes towards mental illness, degree of knowledge about mental handicap, experiences of patient's families. Research findings might identify barriers which if removed may lead to the general public responding and reacting more sympathetically in their attitudes to mental patients in Nigeria. At present the general trend is that people are still immensely fearful of these patients and see mental illness as purely a medical problem without reference to its social routes.

Grad and Sainsbury (1967), for example, have shown through health system's research that home care for the mentally ill/handicapped has serious effects on the people the patient lives with. Families of such patients according to Grad and Sainsbury are found to be presented with and suffer themselves from health problems such as depression, suicidal tendencies, hallucinations, aggression, delusion and so on. Taking Grad and Sainsbury's points further, Clausen (1955); Kreitman (1964); Post (1962) and Rutter (1966) stressed that living with a neurotic patient is very likely to potentiate or even produce neuroticism. Rutter particularly believes that neurosis in patients is more pathogenic for the production of mental illness in children than the presence of any other type of mental illness.

7.4.6 Community Care to Improve PHC

An efficient system of community care to improve basic health care in the rural communities may be achieved if, for example, research investigations are used to explore the value of community care to less fortunate members of the society: the handicapped, disabled, the chronically sick and so on. The purpose of research programmes in community care may be to discover the most appropriate means of achieving:

- i. Supportive services which give assistance to client groups: bathing, personal appearance, shampooing, shaving, trimming nails, helping them to follow a treatment plan that may have been prescribed by a doctor, social worker, occupational therapists etc who are able to demonstrate, help and teach methods of self-help.
- ii. Rehabilitative services which seek to help a good number of patients who are able to return to work immediately after discharge from convalescence, or help others who need a period of special rehabilitation in the community.
- iii. Preventive research efforts may be concentrated in several important areas through community care programmes and designed to support and improve school health, maternity and child welfare and nutrition education.

Community care programmes in Nigeria should not only be provided with adequate resources of finance and materials but must sufficiently attract the services of community health visitors, health education personnel,

primary health workers who understand community organisations and their problems and who can make scientific (PHC) research contribution in these broad areas.

7.4.7 Measuring the Accessibility Of Health Services

Research for (PHC) development in Nigerian can be structured with the object of measuring the accessibility of health services. Any plan to change geographic distribution of health services, whether by concentration or dispersal, has an effect on the accessibility of the service to the population. Accessibility is acknowledged to be important, particularly in the rural areas of Nigeria, but so far no effective methods have been devised in the country commonly accepted for measuring its different facets. Empirical social research investigation has some role to play in this direction. While health service planners in Nigeria are required to provide detailed estimates of the costs to the health service likely to be incurred by the opening of a new health centre, clinic, or hospital in the rural areas, or the transfer of services from one site to another, the travel implications to the community are usually assessed in a much less complete manner. This need not be so. The accessibility to the community of a projected health centre, clinic or hospital in Nigeria cannot be predicted precisely, any more than internal costs can be accurately specified before the event, but it should be possible to produce a useful estimate that goes beyond a simple map of travel times if constructive research investigation leads to a desired effect. Other important issues may include questions about transport facilities or decentralisation of clinics extended to reach, for example, market squares in the rural communities, coastal resort areas of certain parts of Nigeria, where access to health care is very limited due to

their remoteness and isolation: those riverine creeks and delta areas, in the Bendell, Degema, Warri, Bonny communities (etc).

Furthermore, the average distance from patient's homes to the nearest clinic may fall if the number of clinic locations increases. Therefore, the average distance and rate of utilisation of health services in the rural areas of Nigeria may be subjected to empirical studies in relation to the theory that the shorter the distance, the more the utilisation of health services, which in monetary terms may also result in cheaper transport costs for patients (Naira or 'kobo': shillings and pence), a research hypothesis which if investigated may help to determine the implications of clinic distance, patient numbers, mode of transport and cost assumptions most appropriate to seeking health care within the Nigerian rural-setting and to give approximate assessment of community and health services costs to clinics under various conditions.

7.4.8 Relationship Between Poverty and Ill-Health

The relationship between poverty and poor health can be studied and perceived as (PHC) related social problem. Luft (1978), Rowntree (1901) and Booth have all stressed that the interactions between socio-economic factors and ill-health are concentrated primarily on the role of poverty in causing health problems: there may be condition of families, for example, whose total income is insufficient to obtain the minimum necessities of the maintenance of mere physical efficiency; and there may be equally, families whose total income would be sufficient for the maintenance of mere physical efficiency were it not that some of it may be absorbed by other expenditure, either useful or wasteful. Townsend (1951) believes that

individuals, families and groups in a population can be said to be in poverty when they lack the resources to obtain the types of diets, participate in living conditions, and amenities which are customary, or at least, widely encouraged or approved in the societies in which they live. The main causes of poverty are wide ranging: social deprivation, urban/rural decay, unemployment, old age, sickness and so on, which have different effects on people's health, as have been proved by Kincaid (1971), George (1952) and Abel-Smith (1961).

In Nigeria, comprehensive research studies may be important to investigate the extent and depth of both poverty and its health related social problems and the manner people feel about them, especially in the rural communities.

Another dimension of poverty and poor health research studies in Nigeria may relate, for example, to the size of family income, which in many parts of Nigeria, is insufficiently related to family size. The universal theory that is being put forward is that many Nigerian families are in poverty and poor health because of lack of direct government financial assistance to many village people in form of: national insurance system, supplementary benefits, health insurance schemes, subsidies which may help people, at least, in terms of lower health costs or providing them with other social services: housing, road transport and communication, agriculture and livestock improvements. Added to these, many Nigerians in the rural communities do blame both central, state or local governments for substantial low wages, absence of wealth distribution, inadequate tax credit system (etc) which leave most of Nigerian families below poverty line, or in a more direct sense, in absolute poverty.

7.4.9 Other Important Areas for Research

It may be possible to undertake (PHC) research programmes in other important areas in Nigeria, for example, maternity care in order to evaluate alternative policies for better and improved ante and post-natal care. There could be a possibility of carrying out research investigations in Nigeria to study Nigerian diseases and health problems, that are most prevalent, for example, by examining the social and psychological factors that influence the incidence of disease in Nigeria and also determine the ways in which people respond to illness. The social and cultural differences which inhibit communication between those who need medical attention and those who are able to offer it can be investigated through research projects. The research findings might give a clue as why village people in Nigeria tend to accept or prefer traditional medicine to modern medicine and why they do not co-operate on a continuing basis with health centre staff and dispensary workers. Research in this direction might also explore the real possibilities of co-existence of both traditional and modern medical care in Nigeria, allowing all the necessary precautions to make such combined service and union safe for patients. With modern and traditional care co-existing, the values of medicinal plants which are available in greater quantities locally may be scientifically studied by research and this could be done much better if there is active cooperation between them.

CHAPTER EIGHT

SUMMARY OF MAIN CONCLUSIONS

The first point to be made is that primary health care system in the rural communities surveyed is ineffective. The ineffectiveness of (PHC) is due to some important reasons and these include:

8.1 HEALTH SERVICES:

1. The formal providers of health services in these communities (Ibo, Yoruba and Hausa alike) were not giving the people the service they required at the time they needed it, at a cost they could pay, and in a manner acceptable to the village people. As a result, the villagers themselves made little use of the formal system and greater use of traditional healers.
2. At present it would appear that most health care delivery systems in the communities of study were based on a number of assumptions; among these are that
 - a) the understanding of health professionals about the people's needs is correct;
 - b) that the views of health needs held by professionals and by people are identical;
 - c) that people will automatically come to the health professionals to satisfy their health needs,

d) that the right way to promote health is to provide curative clinic based services rendered by physicians, etc. But in reality, the observation of people's health practices and expectations based on these assumptions have been proved to be wrong since they are not being adopted by most of the target populations.

3. The causes of infant mortality in these rural communities are recognised in relation to malnutrition and communicable diseases which are all preventable. PHC system aims to combat these diseases through the efforts of health workers but in these areas have failed because primary health workers, doctors and community nurses working in them are few in number.
4. The majority of people interviewed neither perceived malnutrition as a serious health problem nor reported it as a frequent cause of child death, nevertheless, it is undoubtedly a major threat to child health, whose cause and severity is directly attributed to inadequate knowledge of basic nutritional needs of mothers and children.
5. Rural Nigerian communities have an extensive network of health services, both traditional and modern, which are utilised by the villager in seeking to maintain health. The order of treatment preference from respondents in the study are mixture of two or combination of:

Traditional healing
Religious healing
Health Centre/dispensary treatment
Midwife
Chemist/pharmacy
Shrine
Bonesetters etc.

6. The knowledge of family planning and use of contraceptive methods is insufficient amongst the village people in these rural communities. They lacked full information regarding variety of contraceptive methods - condom, oral pills, IUD, oestrogen etc, but tend to have a desire for a large family. These are obstacles to effective family planning system in these rural areas. Equally, both culture and tradition of the people and their religious practices act as barriers to family planning and educational programmes to effect change. Most women claimed that they had used primitive methods and traditional methods of contraception and that they worked well for them.

8.2 HEALTH EDUCATION:

1. There are many reasons why through health education and health prevention PHC effectiveness is lacking in the rural communities surveyed:
 - i. The village people themselves are not yet quite enlightened about better health habits and practices.

- ii. Some rural communities have populations that are extensively dispersed in these rural areas. It is difficult to get these scattered communities under the network of the available health centres and dispensaries. However, this will not justify government's neglect of the deprived/rural areas.
 - iii. Eventhough (PHC) services have been perceived to be an alternative to conventional curative medical system and inexpensive to run, Nigerian governments (federal and states) have been unable to fund health education programmes adequately.
 - iv. People's involvement in (PHC) decision-making process and in (PHC) activities in general is lacking, just as the government commitment to (PHC) system is minimal in these areas and indeed the whole country.
2. Medical Education - the Nigerian undergraduate medical education needs to be reviewed. It does not need six years of training and sophisticated hospitals in order to be able to prevent or treat the major causes of ill-health among the vast majority of Nigerian poor. In the rural communities of study, the frontline workers in PHC - hundreds of primary health workers and doctors have not been trained in medical duties which are community-oriented and community medicine-based.

8.3 PHC MANAGEMENT:

1. Primary Health Care system in the Nigerian rural communities is ineffective because the Nigerian Health Authorities tend to impose ideas and decisions about PHC activities on people, instead of involving them and letting them to participate fully in PHC activities and PHC decisions.

The village people also tend to remain passive beneficiaries of PHC programmes directed from above instead of being made agents of their own development at local levels.

2. The intermittent services and breakdown of PHC systems in both health centres, dispensaries, communities etc are associated with bad management, lack of staff, bad organisation and inadequate supervision of services.

8.4 PHC MANPOWER:

1. The health manpower development process is fragmented, its components are hardly connected with each other and even less with health services development process, and are thus largely irrelevant to the health needs and demands of the majority of the people. For example, provision of training which is hospital-based and disease-oriented would not solve most of the health problems of Nigerians in the study areas in the foreseeable future.

2. There is no re-orientation programme designed for health workers in PHC services and to motivate staff to develop, manage, supervise and co-ordinate PHC activities in their rural communities.
3. An efficient system of training for work efficiency to improve the skills of staff and consequently the efficiency of the service is lacking in most of PHC institutions in Nigeria.

8.5 SOCIO-ECONOMIC CONDITIONS:

The ineffectiveness of (PHC) system in the three rural communities is observed to be due to some socio-economic conditions in which the village people have found themselves for such a long period of time, and due to some lack of government initiatives for rural development and improvement of rural economy and social services. The main socio-economic conditions that affect (PHC) effectiveness in this direction include the following:

1. Food Production. Each year there have been more malnourished people in these rural communities because of shortage of effective demand for food - village people cannot buy it in these rural communities either.
2. Job Opportunities. With no social security system in these communities and Nigeria as a whole, people have to work. The problem is that the poor people in the study areas do not make enough from the work they do where job is available at all. This

makes payment for medical care difficult. The solution should have been for the Nigerian governments to give rural Nigerian peasants control of sufficient productive resources: land, technology, capital etc to make a living for themselves, and also have enough to enable them pay for medical services they receive.

3. Women's Participation in (PHC) Activities. The women of the study communities have not been given or encouraged to play active role and participate in (PHC) activities and maternal and child services. The village women in these rural communities are mostly illiterates needing to be educated. As with family planning, too often it is the men who take the decisions and women who take the consequences. Women have not been adequately educated about contraceptive methods available and the importance of a family planning system.
4. Population Growth. Linked with the above statement, contraception increases people's control over their lives. But they only lower birth rates if people want less children. It is observed that the village people in the communities surveyed want smaller families only when they are sure that their children will survive, when income increases so that child labour is no longer essential, and when security improves so that children are not the only means of support in illness or old age.
5. The total absence of social services in Nigerian rural communities contributes to PHC ineffectiveness in these areas.

8.6 FINANCE:

There are three main points to be mentioned:

1. Income Distribution. Equitable distribution of income has never been achieved in the rural Nigeria in relation to urban areas and this creates perpetual poverty trap for the rural poor which in turn affects quality of life.
2. Finance. About 80 percent of Nigerian health budgets are spent on expensive city-based curative medicine serving only 20 percent of the population, while 75 percent of the total population, have no access to modern medical care - this situation is found to be most acute in the communities of study where inadequate nutrition, water supply, sanitation etc are common problems.
3. An average household financial expenditure to obtain health services in these rural communities is considerable and is spread over a wide variety of traditional and modern health services.

8.7 GENERAL CONCLUSIONS:

8.7.1 Community

The survey of the three rural communities of study provides the following general conclusions:

1. Although there is a high overall prevalence of illness in these rural communities in Nigeria, it is observed that women and children share a proportionate burden of illness and deaths. The concentration of all deaths occur in children under the age of five, females and of course the aged.
2. A good number of health problems account for a major proportion of all morbidity and mortality: Malaria, measles, diarrhoea, pneumonia, whooping cough, body pains, venereal diseases, child births, malnutrition etc.
3. Lack of information represents a more serious barrier to improved health than does the lack of availability of services. The majority of mothers interviewed, for example, lacked knowledge about the best treatment for common childhood illnesses: diarrhoea, malnutrition and other preventable diseases.

Furthermore, too many village people were seen not to seek or receive treatment outside their homes. Similarly of those treatments known, many are of questionable therapeutic value: malaria, measles etc.
4. The village people tended to perceive their priority health problems as whooping cough, measles, diarrhoea, eye problems, child birth problems etc.

8.7.2 Environmental Sanitation

The three main sanitation problems in the areas of study include:

1. Lack of adequate and wholesome water supply.
2. Lack of latrines in some houses which gives rise to indiscriminate defacation; and
3. Indiscriminate disposal of refuse.

Poverty and ignorance reflects on complete lack of sanitation in these rural communities in which water borne diseases and communicable diseases (typhoid, cholera, dysentry etc) took a heavy toll.

8.7.3 Health Facilities

Health Centres and Dispensaries

1. There are not yet sufficient numbers of health centres and dispensaries to provide a comprehensive health coverage to all populations in the areas.
2. The existing health facilities (health centres, dispensaries, maternity homes etc) are in a bad state and need both improvement and upgrading, maintenance and complete renovation.

3. People have great difficulty in reaching health centres, dispensaries and other facilities to obtain basic health services because of their remoteness from their homes. Furthermore, they have difficulties with transport and communication due to bad roads, lack of public transport, etc.
4. The rural health centres and dispensaries in some areas lack qualified staff while in others the available staff tend to be either under-or-over utilized.
5. Rural health centres and dispensaries represent valued health resources whose full potentials have yet to be realized in these communities, particularly in the areas of health education for mothers and expansion of services beyond the present stationary limits of the centres and dispensaries and into the villages.
6. With the scanty basic facilities in some rural areas which are also ill-equipped, the village people who live nearer to these facilities tend to have not much problems in gaining access to available health centres and dispensaries. Because of this they tend to receive medical treatment when ill much faster than those who live further away from these facilities.

The above conclusions tend to demonstrate that the health of Nigerian populations in the rural areas has been neglected by Nigerian governments and that PHC could only be effective in these areas and fully exploited if the providers of the service adopt appropriate strategies designed to take the services to the people as they would wish them to be.

It is hoped that Nigerian health authorities will take the findings, recommendations and conclusions of this study seriously and use them to promote traditional close links between Nigerian Governments/Local Authorities and the people themselves to improve service effectiveness. The implication of these conclusions is that real long-term change in PHC situation in rural Nigeria may come about through construction of more health centres and dispensaries; modernizing and upgrading the existing ones; preparation of additional manpower levels, including hundreds of Primary Health Workers; provision of Maternal and Child Health services and general basic health care for the ordinary Nigerians. Added to these; rapid progress can be made to improve PHC effectiveness if these conclusions are taken into consideration by Nigerian health planners and Nigerian government in their policy decisions to increase health coverage, to make resources available to meet basic needs (food, clothes, shelter, health, education, transport/communication) of Nigerian people living in rural villages.

APPENDIX ONE

HEALTH ATTITUDE SURVEY QUESTIONNAIRE

PRIMARY HEALTH CARE MANAGEMENT IN NIGERIA

Dear Sir/Madam

HEALTH ATTITUDE SURVEY QUESTIONNAIRE

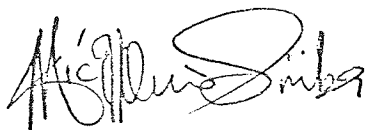
This Health attitudes survey is part of Doctoral Research Study which offers you an opportunity to give your opinions about some of the successes and failures of the Basic Health Service scheme being provided in some Rural areas of Nigeria.

Your replies will be treated in the strictest confidence.

Would you please tick the appropriate box where necessary, which corresponds to your answers or opinion on the issues that have been raised.

Many thanks for your co-operation in completing this questionnaire.

Yours faithfully,



Michael O. Onwuliri
Doctoral Research Programme
University of Aston
Management Centre
BIRMINGHAM

27 March 1984

A HEALTH WORKERS Q1 - 8:

- 1 ANCILLARY AND JUNIOR STAFF
- 2 MIDDLE MANAGERS - SUPERVISORS
- 3 SENIOR MANAGERS - HEADS OF DEPARTMENT

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Case No. 1

Q1 What do you think are the main areas
of greatest health need in your local
community?

9 9 9 1
1 - 4

Personnel:

1	More Primary Health Workers?	1	2	3	4	5	5
2	More doctors and nurses?	1	2	3	4	5	6
3	More supervisors?	1	2	3	4	5	7
4	More health inspectors?	1	2	3	4	5	8

Facilities:

1	More rural health centres and clinics?	1	2	3	4	5	9
2	More hospitals for out-patients, in-patient and referral services?	1	2	3	4	5	10

Drugs and Materials:

1	More vaccines?	1	2	3	4	5	11
2	More refrigerators?	1	2	3	4	5	12
3	More essential drugs?	1	2	3	4	5	13

Information:

1	More communication between health and health-related ministries?	1	2	3	4	5	14
2	More written reports?	1	2	3	4	5	15
3	More medical reporting by the medical profession?	1	2	3	4	5	16

Re-organisation of Current Health Resources
Do You Need:

1	New work groups?	1	2	3	4	5	17
2	Different reporting procedures?	1	2	3	4	5	18
3	New budgetary procedures?	1	2	3	4	5	19
4	New supervisory roles?	1	2	3	4	5	20
5	New training courses?	1	2	3	4	5	21
6	New communication channels?	1	2	3	4	5	22

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Q2 To what extent do the following
affect your community?

1	Malnutrition or kwashiorkor?	1	2	3	4	5	23
2	Malaria?	1	2	3	4	5	24
3	Complications of pregnancy and labour	1	2	3	4	5	25
4	Insect and snake bits?	1	2	3	4	5	26
5	Insufficient drugs?	1	2	3	4	5	27
6	Inaccessible and isolated vilages?	1	2	3	4	5	28

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Q3 Please indicate your agreement with the
statement: "Water transmitted diseases
can be prevented".

1	Hand to mouth : faecal oral diseases.	1	2	3	4	5	29
2	Skin to skin : water-washed diseases.	1	2	3	4	5	30
3	Walking in the water : water-based diseases.	1	2	3	4	5	31
4	Bitten by the water : water-related diseases.	1	2	3	4	5	32
5	Stepping into danger : faecal-disposal diseases.	1	2	3	4	5	33

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Q4 How would you describe the following in your
rural community?

1	Access to water	1	2	3	4	5	34
2	A sewage system	1	2	3	4	5	35
3	Pit latrine	1	2	3	4	5	36
4	Piped water to individual houses	1	2	3	4	5	37
5	Water sources	1	2	3	4	5	38
6	Sanitation facilities	1	2	3	4	5	39

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use only

Q5 Which of the following is practicable in your villages?

1	Simple individual action of cleaning a spring	1	2	3	4	5	40
2	Setting out a pot to catch rain dripping from a roof	1	2	3	4	5	41
3	Rain water collected in drums which can last at least a week	1	2	3	4	5	42
4	Digging a well	1	2	3	4	5	43

Education:

Q6 Re-order the following health and health-related services in order of importance to your local community, starting with 1.

1	Literacy and numeracy	44
2	Preventive health and hygiene	45
3	Nutrition education	46
4	Techniques for increasing food production	47
5	Child-care, home management and family planning	48
6	House improvement and construction skills	49
7	Appropriate local technology	50
8	Local resources and environment	51
9	Participation in community and political life	52
10	Encouraging more females to go to school	53

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Q7 Which of the following characteristics suggests effective PHC to you:

1	A higher level of health	1	2	3	4	5	54
2	A reduction in the levels of illness, disability and death	1	2	3	4	5	55
3	Higher average life expectancy	1	2	3	4	5	56
4	More scope for medical education based in the village	1	2	3	4	5	57
5	Adequate coverage of health provisions/facilities	1	2	3	4	5	58
6	Improved state of hygiene, sanitation and nutrition	1	2	3	4	5	59
7	Community involvement in PHC activities	1	2	3	4	5	60
8	Ready access to essential health care and first level referral facilities	1	2	3	4	5	61
9	Safe drinking water	1	2	3	4	5	62
10	Proper immunization programme against major infectious diseases of childhood.	1	2	3	4	5	63
11	Prevention and control of communicable diseases	1	2	3	4	5	64
12	Availability of essential drugs	1	2	3	4	5	65
13	Adequate transport/ambulance services	1	2	3	4	5	66
14	Government total commitment to PHC programmes	1	2	3	4	5	67

Q8 Which of the following would you include in a health education programme for your village people?

1	Personal hygiene practices	1	2	3	4	5	68
2	Methods of supplying safe drinking water	1	2	3	4	5	69
3	Housing and home improvement	1	2	3	4	5	70
4	Use of mass media	1	2	3	4	5	71
5	Use of native songs, folklore, proverbs, pictures etc. for disseminating PHC information locally.	1	2	3	4	5	72
6	Ways of obtaining necessary food - livestock, fisheries etc. and how to prepare them.	1	2	3	4	5	73
7	Advice and checks on alcohol abuse and cigarette smoking	1	2	3	4	5	74
8	Home economics - types of kitchen, fuel, utensiles etc.	1	2	3	4	5	75
9	Child feeding methods - length of lactation period, age at which solid foods are given etc.	1	2	3	4	5	76

B COMMUNITY 19 - 21 :

- 1 COMMUNITY LEADERS
- 2 HEADMASTERS/PRINCIPALS/TUTORS/TEACHERS
- 3 PATIENTS
- 4 HOUSEHOLDS
- 5 SCHOOL PUPILS

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Case No 1

9 9 9 1

AVAILABLE HEALTH FACILITIES:

Q6 (i) What are the health facilities made
available to your community? (please tick
appropriate box).

1 - 4

1	Health centre(s)	No	1	Yes	2	5
2	Health clinics (dispensaries)	No	1	Yes	2	6
3	Maternity centres	No	1	Yes	2	7
4	Hospitals	No	1	Yes	2	8
5	Private clinics or hospitals	No	1	Yes	2	9

(ii) What is the size of the population of
your community which these health facilities
serve?

10 - 13

(iii) What is the average distance a patient may
travel to reach as defined 1 - 5 above (to
the nearest mile)?

11

14 - 15

(iv) What is the average travel time to reach
as defined 1 - 5 above (in hours and
minutes)?

16 - 19

FOOD

Q10 Indicate how often you eat the following foods:

(a) due to your current behaviour

(b) due to your choice

Your current behaviour

Your choice

FRUITS :

1 Regularly

20 - 21

2 Occasionally

3 Seldom

4 Never

EGGS :

22 - 23

1 Regularly

2 Occasionally

3 Seldom

4 Never

GREEN VEGETABLES :

24 - 25

1 Regularly

2 Occasionally

3 Seldom

4 Never

FISH :

26 - 27

1 Regularly

2 Occasionally

3 Seldom

4 Never

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use only

Your current behaviour

Your choice

MEAT :

- 1 Regularly
- 2 Occasionally
- 3 Seldom
- 4 Never

28 - 29

YAM :

- 1 Regularly
- 2 Occasionally
- 3 Seldom
- 4 Never

30 - 31

MILK :

- 1 Regularly
- 2 Occasionally
- 3 Seldom
- 4 Never

32 - 33

MODERN MEDICINE

Q11 Are the following allegations about modern medical care in your community true or false?

	True 1	False 2	
1			34
2			35
3			36
4			38
6			39
7			40
8			41
9			42
10			43
11			44
12			45

13	Waiting time to obtain medical treatment is sometimes too long.	46
14	There is little or no privacy for diagnosis or undressing.	47
15	A long journey is made to reach the nearest health centre.	48

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Q12 The concern of some families in your village about contraception may include the following:

1	Lack of knowledge on the variety of contraceptive methods.	1	2	3	4	5	46
2	Insufficient husband/wife discussion about contraception.	1	2	3	4	5	50
3	Desire for a large family.	1	2	3	4	5	51
4	Lack of concern for pregnancy and its complications.	1	2	3	4	5	52
5	The importance of having a son.	1	2	3	4	5	53
6	Demographic problem.	1	2	3	4	5	54
7	Religious and moral beliefs.	1	2	3	4	5	55

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Q13 What would be your expectations when receiving medical treatment?

1	Is there a friendly and helpful reception?					
	No	1	Yes	2		56
2	Do any patients have to wait longer than 15 minutes in the out-patient clinics?					
	No	1	Yes	2		57
3	Is adequate medical attention given?					
	No	1	Yes	2		58
4	Is there prompt, unhurried attention at all stage of the clinic?					
	No	1	Yes	2		59
5	Is there consideration of patients complaints?					
	No	1	Yes	2		60
6	Is there a clear understand of advice given?					
	No	1	Yes	2		61

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SMOKING, DRINKING (TOBACCO AND ALCOHOL):

Q14 Please indicate the characteristics you prefer :

Your Current Behaviour

Your Choice

SMOKING:

62-63

- 1 Regularly
- 2 Occasionally
- 3 Seldom
- 4 Never

DRINKING:

64-65

- 1 Regularly
- 2 Occasionally
- 3 Seldom
- 4 Never

TRADITIONAL MEDICINE:

Q15 Are the following allegations about traditional medical care in your community true or false?

	True 1	False 2	
1	Traditional healers are cheap to consult.		66
2	Illness profile of a patient is considered from cultural or religious background.		67
3	Traditional healers can reach remote villages and isolated rural areas.		68
4	Trade in ingredients for traditional medicines can be made, both long distance and local.		69
5	Traditional healers are too secretive.		70
6	Nigerian Medical Council has not yet licensed traditional healers but is beginning to recognise the role of traditional medicine in modern medical thinking and that traditional and modern may co-exist.		71
7	Traditional healers are the true local general practitioners and spiritual advisers		72
8	Traditional medicine had kept many Nigerians alive prior to the advent of Western medicine.		73
9	Traditional medicine is an established part of Nigerian culture.		74

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Q16 How would you describe the state of
transportation in your village

1	Roads	1	2	3	4	5	5
2	Seasonal weather	1	2	3	4	5	6
3	Government's funding	1	2	3	4	5	7
4	Control of flooding	1	2	3	4	5	8
5	Standard of driving	1	2	3	4	5	9

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Use Only

Q16 How would you describe the state of
transportation in your village?

1	Roads	1	2	3	4	5	5
2	Seasonal weather	1	2	3	4	5	6
3	Governments' funding	1	2	3	4	5	7
4	Control of flooding	1	2	3	4	5	8
5	Standard of driving	1	2	3	4	5	9

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Q17 How possible is the provision of the following out-patients clinic services in your community health centre or hospital?

1	Treatment of simple disease and short illness by out-patient care.	1	2	3	4	5	10
2	Initial treatment of serious illness pending referral to a rural health	1	2	3	4	5	11
3	After-care, if required, of patients discharged from hospital.	1	2	3	4	5	12
4	Participation in immunization and community health and nutrition programmes.	1	2	3	4	5	13
5	Maternal and child health care.	1	2	3	4	5	14
6	Rural sanitation and environment hygiene.	1	2	3	4	5	15

HYGIENE AND SANITATION:

Q18 Which of the following services do you consider very important to your local community?

1	Provision of sewerage and sewage disposal	1	2	3	4	5	16
2	Inspection of villages for detection of nuisances and their abatement	1	2	3	4	5	17
3	Provisions concerning infectious diseases designed to protect individuals and community.	1	2	3	4	5	18
4	Provisions relating to composition and purity of food and hygiene	1	2	3	4	5	19
5	Removal of household refuse	1	2	3	4	5	21
7	Standards in construction and maintenance of premises where local foods are prepared or sold.	1	2	3	4	5	22

Q19 What expectations does your community have about Primary Health Workers.

1	Community involvement in their initial selection, training, depolyment and payment of their salaries and other remunerations.	No	1	Yes	2	23
2	Retraining of Traditional Birth Attendants.	No	1	Yes	2	24
3	She/he should be a member of Primary Health Team.	No	1	Yes	2	25
4	She/he must be selected from the village she/he has knowledge of and lived in for a long time.	No	1	Yes	2	26
5	She/he should be able to deal with:					
	- Communicable diseases.	No	1	Yes	2	27
	- Maternal care	No	1	Yes	2	28
	- Child health and nutrition	No	1	Yes	2	29
	- Village sanitation	No	1	Yes	2	30
	- Home sanitation	No	1	Yes	2	31

Q20 Which of the following would you include in a health-education programme for your village people?

1	Personal hygiene practices	1	2	3	4	5	32
2	Methods of supplying safe drinking water	1	2	3	4	5	33
3	Housing and home improvement	1	2	3	4	5	34
4	Use of mass media	1	2	3	4	5	35
5	Use of native songs, folklore, proverbs, pictures etc. for disseminating PHC information.	1	2	3	4	5	36
6	Ways of obtaining necessary food - livestock, fisheries etc. and how to prepare them	1	2	3	4	5	37
7	Advice and checks on alcohol abuse and cigarette smoking.	1	2	3	4	5	38
8	Home economics - type of kitchen, fuel, utensils etc.	1	2	3	4	5	39
9	Child feeding methods - length of lactation period, age at which solid foods are given etc.	1	2	3	4	5	40

Q21 Which of the following characteristics suggests effective PHC to you?

1	A higher level of health	1	2	3	4	5	41
2	A reduction in the levels of illness, disability and death	1	2	3	4	5	42
3	Higher average life expectancy	1	2	3	4	5	43
4	More scope for medical education based in the village	1	2	3	4	5	44
5	Adequate coverage of health provisions/facilities	1	2	3	4	5	45
6	Improved state of hygiene, sanitation and nutrition	1	2	3	4	5	46
7	Community involvement in PHC activities	1	2	3	4	5	47
8	Ready access to essential health care and first level referral facilities	1	2	3	4	5	48
9	Safe drinking water	1	2	3	4	5	49
10	Proper immunization programme against major infectious diseases of childhood	1	2	3	4	5	50
11	Prevention and control of communicable diseases	1	2	3	4	5	51
12	Availability of essential drugs	1	2	3	4	5	52
13	Adequate transport/ambulance facilities	1	2	3	4	5	53
14	Total Government commitment to PHC programmes	1	2	3	4	5	54

B PRIMARY HEALTH CARE MANAGEMENT Q22 -24:

- 1 SENIOR HEALTH MANAGEMENT OFFICIALS
AT HOSPITAL AND HEALTH CENTRE LEVEL
- 2 SENIOR HEALTH MANAGEMENT OFFICIALS AT
MINISTRY OF HEALTH LEVEL

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Case No 3
9993

Q22 The success or failure of PHC in some of your rural communities may have been attributed to the role of the management. In which category would you place the following management activities in relation to PHC:

1	Decentralisation of PHC activities under local government control and finance	1	2	3	5
2	Direction: delegation, motivation, leadership, co-ordination, communication etc.	1	2	3	6
3	Management training for: i middle management ii senior management	1 1	2 2	3 3	7 8
4	Training of other health workers	1	2	3	9
5	Budgets and budgetary control	1	2	3	10
6	Response to the attitudes of the village people towards existing health services	1	2	3	11
7	Distribution of health resources equitably	1	2	3	12
8	Involvement of local community	1	2	3	13
9	Provisions for health services/facilities	1	2	3	14

Q23 Which of the following would you include in a health education programme for your village people?

1	Personal hygiene practices	1	2	3	4	5	15
2	Methods of supplying and storing water safely for drinking	1	2	3	4	5	16
3	Housing and home improvements	1	2	3	4	5	17
4	Use of mass media	1	2	3	4	5	18
5	Use of native songs, folklore, proverbs, pictures etc. for disseminating PHC information	1	2	3	4	5	19
6	Ways of obtaining necessary food: livestock, fisheries etc. and how to prepare them	1	2	3	4	5	20
7	Advice and checks on alcohol abuse, cigarette smoking	1	2	3	4	5	21
8	Home economics: types of kitchen, fuel, utensils etc.	1	2	3	4	5	22
9	Child feeding methods: length of lactation period, breast feeding, age at which solid foods are given etc.	1	2	3	4	5	23

Q24 Which of the following characteristics suggests effective PHC to you?

1	A higher level of health	1	2	3	4	5	24
2	A reduction in the levels of illness, disability and death	1	2	3	4	5	25
3	Higher average life expectancy	1	2	3	4	5	26
4	More scope for medical education based in the village	1	2	3	4	5	27
5	Adequate coverage of health provisions/facilities	1	2	3	4	5	28
6	Improved state of hygiene, sanitation and nutrition	1	2	3	4	5	29
7	Community involvement in PHC activities	1	2	3	4	5	30
8	Ready access to essential health care and first level referral facilities	1	2	3	4	5	31
9	Government(s) total commitment to PHC	1	2	3	4	5	32
10	Safe drinking water	1	2	3	4	5	33
11	Proper immunization programme against major infectious diseases of childhood	1	2	3	4	5	34
12	Prevention and control of communicable diseases	1	2	3	4	5	35
13	Availability of essential drugs	1	2	3	4	5	36
14	Adequate transport/ambulance services	1	2	3	4	5	37

APPENDIX THREE

DIFFERENT PHC PROGRAMMES IN RURAL NIGERIA

APPENDIX THREE

DIFFERENT PHC PROGRAMMES IN RURAL NIGERIA

DIFFERENT PHC PROGRAMMES IN RURAL NIGERIA

1. THE ARO VILLAGE: The need for the Aro village psychiatric day hospital is to enable the therapeutic techniques of an ordinary mental hospital to be applied to patients who remain in their own social environment. This is of particular benefit to Nigerian peasant, because, not only does he find a hospital ward a strange and disturbing place, but his own close knit society has exceptionally strong social and human resources which promote his mental health. Amongst these resources are the natural flexibility and tolerance of village communities the therapeutic value of traditional cults, and the confessions, dances, songs, proverbs, folklore, rituals etc. that play so large a part in peasant and rural communities in Nigeria. Acting together these provide strong natural psychotherapy. It is the possibility of combining all these natural therapeutic resources with psychiatric methods of Western medicine that is of such great value to a Nigerian villager when he is mentally ill.

Family loyalty is essential for success and Aro village offers all the natural advantages as a typical Nigerian village. It serves a large part of Western Nigeria, and indeed patients from outside the village itself attend the hospital. This means that most of these patients have to be boarded out in Aro village while the clinic remains very accessible to them. A relative of a patient has a role to play which must be clearly defined while his co-operation is sought at all times. This relative has to be devoted to the patient. This means that care of this nature is only possible where families are closely knit, and there is a real sense of mutual obligations of the members. Patients are usually accompanied by relatives who stay with them and bring them up to the outpatient clinics, and when formal

treatment is over, patients are given occupational therapy and then return with their relatives to their village lodgings late in the afternoon.

A community psychiatric nurse is always on duty in the village to reassure its inhabitants and to deal with insomnia or any other symptoms that may arise. She is assisted in her tasks by a guide who looks after the relatives of patients. The Aro families who volunteer to take in some of the patients and relatives are paid monthly for the services they offer patients, and building loans are also provided so more accommodation are made available. There is, however, a maximum to the number of patients that a village can hold, and no more than two patients are allowed for every three of its inhabitants. Following organisation of services at Aro village, many benefits have accrued to the villagers. They now have a piped water supply, a clinic, a mosquito eradication squad and pit latrines. Their economic status has also improved as some of them are able to find work as porters or gardeners in the village.

The closest co-operation has been maintained between the medical staff of the hospital and the village communities. To make this much easier, chiefs from the village are represented on the governing body of the hospital, and likewise, the physicians from the hospital interest themselves in the community health and administration of the village.

It might be thought that only the most socially adapted patients could be treated in this way. In practice this is not so, and even violent cases have been successfully treated in the village. Some patients who have exhibited aggressive or anti-social tendencies in their own homes have become quite manageable once they settled at Aro village.

Not every case though is cured, and the hospital has been faced with the problem of how to dispose of those patients who fail to recover, even at a social level, a problem which has of recent been aggravated by the cultural and economic changes taking place in Nigeria. Even the most devoted relative who accompanies a patient can only stay for a comparatively short time, and when an illness becomes protracted, none can afford the financial sacrifice of staying in the village indefinitely. The answer to the challenge of chronic patient lies in a new experiment at social periphery - the Aro hospital village farm.

The Aro hospital village farm was introduced as agricultural work is that best suited to the chronic psychiatric patient, hence the use of several big farms in the vicinity whose owners were prepared to adopt chronic patients as labourers, while they are still receiving treatment. Such patients continue to be supervised by the hospital authorities, and their homes. Many patients end up building their own huts on these farms as an indication of their willingness to settle in the area permanently and a good sign that they are also getting better and recovering very well. The village of Aro experiment is hoped to become a useful model that could be extended and adopted in many other systems of psychiatric care in Nigerian rural communities.

The pioneers of Aro village hospital also believed that traditional healing also plays some important role in psychiatric care as expressed by Lambo (1971) who says: "One of the unusual features of our care of the mentally ill in Nigeria is our unorthodox collaboration with traditional healers. We have discovered, through long practice in Africa, that in understanding the

African patient in his social environment, it is essential to work in close collaboration with other disciplines, and even to establish some form of inter-professional relationship with those who, by Western standards, are not strictly regarded as professional. My Sudanese colleague Dr. Tijani El Mahi and I, have for a number of years made use of the services of African traditional healers, whom we have specially chosen to help us in social psychiatry - an indefensible practice by Western standards. With their help we have enriched our knowledge of the natural history of the mental disorders in our communities. Without them we would have been at a loss in searching for the psychological causes of the neuroses that are so common in African communities undergoing rapid social change. Most of the traditional healers with whom we have to co-operate have had long experience in managing African patients and are thus able to supervise and direct many group activities among the patients at Aro. They work under strict supervision and many participate in our epidemiological surveys as contact men".

ADVANTAGES AND LIMITATIONS:

The experience of Aro village psychiatric health scheme has its advantages and disadvantages. The advantages may include the following:

1. it secures for the mentally sick the full benefit of dynamic resources promoting mental health that are present in the patient's own communal environment.
2. When mental patients are treated in a community the social attitudes towards them and towards mental disease become more relaxed and better adapted. This is especially true of the

patient's relatives, the social stigma attached to psychiatric disturbance is greatly reduced.

3. A patient's adaptation to society - his degree of social competence - can be judged more readily when he is a member of a normal community than it can in the artificial environment of a mental hospital.
4. All kinds of mental illness can be treated at Aro psychiatric day hospital, provided that there are a few psychiatric beds for emergency use.
5. The psychiatric day hospital deploys meagre human and material resources to the best advantage which is economical to the medical authority to the patient and to his relatives.
6. This kind of mental care is ideally suited to the closely knit pre-industrial and agrarian societies of Africa and Asia with their high thresholds of community tolerance.

The Aro village hospital has some disadvantages also:

1. The psychiatric day hospital is seldom possible in the loose-knit, critical, success oriented societies of industrial countries and it will probably not long survive the advent of social change in developing nations. Even in Nigeria, nobody has yet been able to get occasional patients from a general hospital looked after in an ordinary village.
2. Really sympathetic administration and good public relations are critical to its success.

2. THE IKIRE VILLAGE: An experiment and a feasibility study on Expanded Programme on Immunisation was done in a village of Ikire in Oyo State. The scheme was essentially based at Ikire health Centre and with the help of community organisations and community involvement, immunisation services were organised in which a mobile team commenced operations in the village after receiving practical training at the Epidemiological Unit of the Oyo Ministry of Health

Vaccines were delivered on two contacts with a child in the village. During the first contact with a child aged between 3 to 21 months; BCG, first dose DPT and first dose Polio were administered. At the second contact with the child aged between 6 to 24 months, small-pox, measles, 2nd dose DPT, 2nd dose of polio were given, and at the same time, all women in childbearing age group received tetanus toxoid vaccine. The assessment of the coverage was done through scar surveys (BCG - first contact antigen, small-pox - second contact antigens).

Some temporary vaccination centres were also established in addition to the existing health centre for the purposes of seeking the support of community leaders, mobilising community groups, informing the target groups, meeting traditional healers to secure their co-operation, conducting the vaccination sessions, follow-up of non-attenders etc.

The health centre staff were primarily responsible for the overall responsibility and direction; control, supervision and evaluation; supplies distribution control; collection and compilation of reports etc.

The Ikire immunisation programme was successful when considered from several viewpoints; for example, there was:

1. Community involvement
2. The State government backed it up and funded it.
3. The health workers showed interest and support
4. Public support for the programme which brought about acceptance.
5. Adequate supervision and evaluation.

As a result of Ikire's experience, the Federal Military Government (1979) decided to launch the programme on a national scale and provided considerable sum of money for the purchase of vaccines and equipment. The WHO Regional Office for Africa had also been involved in the planning and management programmes of the immunization campaign.

3. THE MARKETING OF HEALTH SERVICES IN THE VILLAGE OF ARAROMI: Araromi is a rural village with a small local market square where villagers go to buy or sell items of food, clothes etc.

Araromi has a small ill-equipped health centre but it was long discovered that the villagers had resented seeking health care in it for various reasons which will be discussed later.

Bad roads and lack of transportation are the major barriers that make Araromi inaccessible almost all year round. But it was discovered that despite these communications barriers, Araromi villagers are not deterred from going to the local market which is open on four daily basis.

A primary health care team were sent from Lagos State Ministry of Health to offer the village some practical health education which may help in reducing their common health problems observed in the village.

It came as no surprise about the villagers reactions to the team's visit, because in the past, they have always associated anything from the Central or State governments with payment of taxes for which they felt they got little in return. But the truth about the visit had nothing to do with taxation, or the hated breed of tax collectors.

The team's strategy was shifted in which they had to settle in the village and interact and communicate with the villagers more so that they would understand them and be understood better.

The health education sessions carried out in the village market square in which the team sought not to impose solutions of their own or draw attention to the villagers' problems they felt should be given priority, but rather, to let the community members through 'self-diagnosis', discover their health problems and health needs, while the team would remain advisers, observers, supervisors etc.

The village councillors met on a number of occasions with selected members of the community in which a decision was taken to allow the first experimental but practical health education to proceed. If the health team were selling better health, would the villagers buy?

The first market audience were given some health education via demonstrations, posters, written local language handouts, methods of constructing pit latrines, methods of improving drinking water to make them safe, films etc.

In order to secure approval or acceptance of the above experimental schemes, the team decided to recruit or employ villagers to man these experimental health schemes especially on market days. The news about these health education programmes and initiatives spread very quickly at Araromi village and adjacent villages. Many other villagers voluntarily came forward to ask questions about their health, showing considerable interests in the health education programmes. The surrounding villages requested the health team to set up similar schemes in their rural communities. This was done, and these other villages benefitted from the fast spreading health education schemes while the health team still maintained close supervision and training sessions between intervals at Araromi, as a means of ensuring efficient follow-up system. With passage of time, skill and experience, Araromi village was able to set and run a very formidable village Health Committee which undertook several primary health care activities, including planning local health problems, decision-making on local health matters, etc. The membership of Araromi Village Health Committee included health assistants, midwives, traditional healers, traditional birth attendants, local school teachers etc. A local school teachers was appointed a Secretary and one of the midwives became the treasurer by appointment.

Other sub-committees were also set up so that primary health care team in the village would be closer to the grassroots and were able to put some useful suggestions, for example:

1. that the stream from which most of the community drew water should be enlarged and protected from pollution until a deep well is dug.
2. that the community build at least six pit latrines in various parts of the village which may serve as public lavatory.
3. that an incinerator be built near the market square
4. that drinking water be boiled, filtered and stored in clean containers
5. that food for sale be protected
6. that indiscriminate spitting and defecation be made punishable offences.

Achievements were made because the villagers themselves accepted the schemes united and co-operated with PHC officials. The results are remarkable:

1. The village streams were fenced round and their sources properly protected from contamination.
2. Any type of food for sale or for personal use was covered to prevent flies tramping on it to contaminate it.
3. The Traditional Birth Attendants became involved in keeping records of births and encouraged to ask for help when necessary from the trained midwives.
4. Efficient referral system was established with the agreement of health centres and the general hospital that is not too far away from the village.

5. An exchange visiting programme was launched between the Primary Health team and the village health committees to discuss and exchange views on health matters in the village.
6. The surrounding villages that adopted the schemes also became successful.
7. Breastfeeding was encouraged and practised.
8. Food demonstrations were frequently organised to promote good food habits.

Problems. Although the majority of Araromi village people welcomed the health education campaign, it was soon discovered that a good many of them also resented eating some local food items that are rich in protein and minerals: paw-paw, orange, banana, vegetables, etc. Araromi people have only yam and cassava, like many other Nigerians, as their staple food and these are only starchy food tubers, in addition to other junk foods.

Another serious problem that has been observed is that despite the good response shown in the health education schemes, the village people have not yet formed regular habits of disposing refuse or to make use of the incinerator that was provided in the community.

4. **THE OGBUNKA HEALTH AND COMMUNITY DEVELOPMENT PROJECTS:** The Ogbunka Health and Community Development projects were initiated by the Teachers and Students Association of Ogbunka with active collaboration with the village chiefs.

The projects were both short-termed and long-termed and backed up by the Orumba County Council in the Anambra State, which had earlier revealed

that governments were willing to support village health and community development projects if they saw genuine interests and involvement of the villagers themselves.

The main short-term projects were programmed to include the following:

1. Provision of basic health facilities for primary health care in the village, including maternal and child care, health education etc.
2. To build two secondary schools - one for boys the other for girls.
3. Conversion of the old village postal agency into modern Post Office.
4. Improvement of roads and general infrastructure of the village.
5. Erection of a village public hall.
6. A sustained scholarship programme Awards for Ogbunka promising young students.

The long-term projects were scheduled to include:

1. Improvement of water sources.
2. Building a rural hospital and more health centres and clinics.
3. Attracting local co-operatives and small local businesses.
4. Agricultural improvements etc.

The government's actions are in line with their policies for self-reliance and decentralisation of health and community development activities, while placing emphasis on greater use of resources in the rural and peripheral areas.

The beginning of each of the above projects started and focused on an analysis of local situations of the village, for example, dominant community problems, community patterns that would have direct effect on the proposed programmes, local and government resources etc.

Information concerning dominant community problems and traditional patterns was collected by carrying out a survey of the community members. Views expressed by those with most experience in relation to communities, for example, school teachers, community leaders etc were taken into consideration. A team of malaria workers were contacting villagers and collecting information etc. These surveys were conducted to demonstrate the need for greater awareness of the problems that existed in the village, the potential means available to alleviate these problems and the ways in which the villagers could organise themselves to facilitate actions.

The provisions for basic health care were supported with health education programmes, for example, mother craft teaching about conception, hygienic measures for pregnant women, nutrition pregnancy, breast care in pregnancy and puerperium, breastfeeding etc.; family planning; family care; emergency care; giving simple medical treatment etc.

There has been some work done to improve village water supplies but technical details have shown that further appropriate advice and possibly, materials for capping springs, hand-digging wells, surface water retention, purchase and maintenance of hand-pumps to complement village contributions of labour and money, would be needed before local water supply problems can be solved.

Strong traditional forms of decision-making and co-operative effort exist in the rural areas of Ogbunka, and it was this which favoured community involvement. A remarkable interest and willingness on the part of the community to identify problems and work toward their resolution has been shown. But it is also apparent that Ogbunka communities expect the State and local governments to support their local efforts in various ways more, particularly by giving advice, technical assistance, loans etc. to support local efforts to accomplish tasks. This is more important to the villagers as they have always achieved excellence in paying their taxes in time. In turn, they expect to see tangible benefits from taxation imposed. But sometimes these villagers have tended to question whether they should perform functions which they perceive to be government responsibilities. This argument has time and time again sparked off some local disputes and disagreements as the poorer villagers feel the burden of increases in taxation the more. Disputes also arose due to social divisions and sectional interests and differences about who should have what: health centres, clinics, maternity homes etc. These disputes in turn slow progress or make both continuity and co-ordination of activities difficult to achieve.

1. AN INTEGRATED MCH/FP SERVICE PROJECT IN THE CALABAR DIVISION WHICH IS SUPPORTED BY UNITED NATIONS FAMILY PLANNING ASSOCIATION (NNFPA): This project covers a total population of 200,000. The project was initiated as a result of an awareness of the great importance of setting up some link between the health centres and the homes of the consumers of the service. Therefore a category of community workers, designated "Family Health Workers" was created. These are girls with standard VL primary education; there are at

present 34 of them altogether - two covering each large village group. The FHWs are given a three-month training in MCH/FP, home visiting, care of under-fives, etc. A month of the three-month training is spent at the Institute of Public Health.

From its inception, the project attached a great importance to the need for fruitful cooperation and collaboration between the conventional health service and the traditional healers with particular emphasis on the TBAs. The latter receive supplies of sterile packs containing gauze, ligatures, etc. The collaboration with the TBAs has already resulted in an improvement of the birth registration in the area concerned.

The FHWs are selected by their local communities. They live in the villages and hold clinics on their own. These are mainly concerned with nutrition assessment (using the mid-arm circumference technique) and with immunization programmes.

2. THE ITIGIDI HOSPITAL PROJECT: This is a voluntary agency hospital. In this project Clinic Helpers (CHs) are selected by the local communities - chiefs, women's guilds etc. Besides this crops of frontline workers, auxiliary nurses are trained for a period of 3-6 months. This cadre is primarily involved in mobile MCH work. As a general rule, three of these auxiliary nurses, supervised by the community nurse, organize at regular intervals clinics in specified villages with the active participation of the clinic helpers. During these clinics, a list of villages who should receive domiciliary services is drawn up. The CHs work for three days each week: two spent on home visiting and one on mobile clinic work. In addition to the active participation of the community in the selection of

the clinic helpers, the community elders contribute in cash or in kind to the construction of simple buildings (or pay the rent for hiring of such a building) for holding clinics. Furthermore, each patient pays 10 Kobo as a registration fee; and these fees help to meet part of the salaries of the clinic helpers.

For every 10 villagers there is a leprosy inspector responsible for case-findings and for treatment. These inspectors are assisted in their work by the clinic helpers.

3. OGOTA AREA PROJECT: Here non-literate women (usually married and with children) are selected by the chiefs. They are given a two-day training each month - the training is concerned mainly with standard treatment for fevers, diarrhoea, etc. The patients usually pay for the drugs supplied by this corps of female workers, so far, over 20 villages of the area are covered by the project.

4. THE IRGRO-ORA SCHEME: This is run under the aegis of the Department of Community Medicine of the University College Hospital of the University of Ibadan. It aims at providing PHC for the Ibarapa area which has a total population of 200,000. It is concerned mainly with ante-natal and child care and immunization programmes. An important aspect of the schemes activities concerns domiciliary visits by field workers.

There is also a programme for the training of health workers for various grades (mainly of the auxiliary categories), and some operational research.

5. THE MALUMFASHI PROJECT: This project which is involved in rural health care delivery services has two components: one concerned with the field training of the health teams and the other with service delivery. There is no training programme for local community personnel. The project is a collaboration effort between the Department of Community Health of Ahmadu Bello University and Finnish bilateral assistance.
6. THE CALABAR TOWN PROJECT: This a project in which the Institute of Child Health of Lagos University is directly involved. It concerns some 30,000 inhabitants of the Calabar urban area. The service given by this project has two components: one clinic-based, and the other community-based. Nurses are given training in immunization programmes and health education, including nutrition. Field health workers are concerned almost exclusively with community health work. There is also a research component designed to evaluate the impact of the service delivery system on the community.
7. THE KATSINA PROJECT: This covers an urban population of some 20,000. It gives the same type of service as 6 above.
8. THE SHOMOLU PROJECT: Here again the field health workers render the same type of service as in 6. In addition, the Lagos University was the project for the initiation of medical students to the overall concept of PHC.
9. THE SOKOTO PROJECT: This is concerned mainly with MCH work, including child spacing.

Traditional birth attendants are being trained by the Sokoto/Niger State's project in which WHO, UNDP and UNFPH are collaborating. Started in the first half of 1975, the project had trained 120 TBAs by 1976. These TBAs are supplied with simplified kits provided by UNICEF. The latter also provides a stipend of some ₦ 8.00 for each TBA per month. The TBAs so far trained are making a valuable contribution, and the villagers now expect all of them to have undergone the simplified training organised by the project. It was reported that one particular TBA of that area is a very important referral authority in both Kano and Kaduna States have demonstrated a positive interest in starting a TBA training programme; a two-day seminar on the use of traditional healers (particularly TBAs) in health care delivery is planned in Lagos State.

10. THE GARKIDA PROJECT IN GONGOLA STATE: This project is run by a mission agency with the participation of the community. Village workers are selected by the community for training in environmental health and health education. They are remunerated by the community.

11. THE PRIMARY EDUCATION IMPROVEMENT PROJECT (PEIP) OPERATING IN THE NORTHERN STATES: The project is involved with curriculum development up to primary IV in the field of nutrition, home economics and basic health care. There are in all seven projects covering 700 schools in the North. UNICEF has supplied visual aids and other educational materials to the Ahmadu Bello University for use in the project.

There was a general consensus that the projects described above constitute a very small beginning in the field of primary health care delivery in Nigeria. In the main, they are patchy and isolated programmes. What is really needed is a national policy on PHC delivery in the Federation. It was felt that the Local Government Reform Decree promulgated by the Federal Military Government in 1976 and designed to improve grass-root administration, with the active involvement of Local communities in their own development programmes, will contribute substantially in the future to the acceptance of the PHC philosophy in its global context. The Local Governments in each State were scheduled to become operational in January 1977.

COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE

Community involvement in primary health care may be said to occur where the less privileged members of a society (especially the grass-roots) take part in the authority and managerial processes and functions of basic health activities in their local community. There may be occasions, however, when the community involvement in primary health care and management processes - decision making, planning etc - may run counter to the intentions and interests of the management as well as in their favour.

When local communities are actively involved in primary health care activities, they may be able to, for example:

1. joint in discussions and help make decisions
2. find out who has access to basic health care and who does not within their rural villages

3. find out through discussion with village chiefs what health problems are of greatest concern to them
4. discuss possible ways of improving health services in the village, as well as community development in general
5. use health resources more efficiently.

King (1966) pointed out that medical services should be organized from the bottom-up and not from top down, and that the health needs of a community must be related to their wants.

King also believes that medical care, as contained in his 12th axiom, must be carefully adapted to the opportunities and limitations of the local culture.

Based upon local community organisations in some of Nigerian rural communities, the health policies of some states, funds available, health manpower levels, training facilities etc there seems to be some awareness for community-spirit and involvement in primary health care activities in some Nigerian rural communities and the main reasons for active involvement of the local people include the following:

1. Defence and promotion of community interests in health and socio-economic matters.
2. Democracy prevails for every member of the local community.
3. Promotion of personal fulfilment in the village by giving them social and economic opportunities: jobs, career, etc in their own village.
4. Effective utilization of health resources:

- (i) Community citizens have ideas which can be useful for health promotion
 - (ii) Effective communication upwards is good for decision-making at the top when the views of the grass-roots are taken into account
 - (iii) Community will accept decisions better if they are involved in the decision-making process
 - (iv) Communities are better informed about reasons for and the intention of decisions
 - (v) Community will foster more co-operative attitudes among community members and management, thus raising efficiency.
5. Greater community influence over health matters that affect them.
6. Promotion of community interests.
7. Greater management efficiency, the greater community satisfaction.

However, in Nigeria as a whole, there is no one co-ordinated movement of public participation in primary health care activities, but rather a number of separate movements, some as spontaneous reactions to personal or local situations. There have been a few Nigerian village health committees which tend to represent the interests of their communities in health matters. This action was intended to separate the role of representation of the public from that of management of health services and also as a response to the consumer movement through which Nigerian village people have been seeking greater say in health and community matters that affect them. But public participation in primary health care in the rural areas of

Nigeria is increasing in different forms, for example, in the form of patient participation in some health centres and hospitals. This may take the form of groups of patients of a health centre, for example, meeting with the medical staff of their health centre to improve communications between them and to discuss such matters as the running of the centre's practice, health education, use of hospital services and health care in the community. The members of local groups are sometimes selected or nominated by the community themselves or by the village health committees where they are available or by the medical profession themselves. These different groups when nominated, do have different emphasis about the method of participation they prefer, for example, some groups may be keen on the idea of participative management and might wish to know more about what their local community wanted from its community medical practitioners and hence would wish to seek representatives from all local organisations, including the church and clergy. Other group representatives may be interested in a more open kind of medicine and set-up a committee elected by patients to meet, for example, monthly with sub-committees where necessary, to discuss different health topics for necessary improvements. Still, other group representatives may wish to give patients a say in the running of health centres and to provide an opportunity for investigating patients' and public complaints surrounding how well the health services meet community health needs and expectations or whether community expectations about health services being provided differ from those of health care delivery establishments. A number of other issues may also be discussed such as opinions on conditions at particular health centres, clinic, hospital etc; references to experiences of local doctors about community health care; problems of the local retail pharmacy service; the most probable

geographical distribution of patients', measuring distances between patients' homes and clinics; inferences being drawn about modes of transport, costs and times etc.

This form of participation in Nigeria where they exist, provide the kind of patient/consumer participation and make for real dialogue between health service professionals and their patients but its success depends not entirely only on these community group representatives but also on the interest and enthusiasm shown by the medical profession which must involve substantial number of Nigerian doctors. In this way a two-way communication pattern would be established between the providers of health care and the recipients which breaks the rigidly defined professional barrier too common in Nigerian health service.

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